CHAPTER 4: DETAILED PBP DATA ENTRY

PBP FEATURES & POLICY CLARIFICATIONS

Cost Share Amounts

Cents can be entered with dollars in all fields that collect monetary amounts, including Copayments, Deductibles, Maximum Plan Benefit Coverage, Maximum Enrollee Out-of-Pocket Costs, and Premium amounts.

Enhanced Benefits

Enhanced benefits are benefits designated as Additional, Mandatory, or Optional Supplemental benefits that are offered by the MCO as part of the plan but not covered by Medicare.

Guidance for Value Added Items and Services Language

NEW FOR 2004:

The Value Added Items and Services (VAIS) as defined in the CY 2004 Call Letter state that "Words such as rebate, allowance, and discount are not permitted in the PBP since they're describing a VAIS. An exception to this rule is allowed when describing prescription drug discount programs. " Therefore, in CY 2004, CMS will **NOT** approve the ACRP filing with the words "rebate", "allowance", and/or "discount" in the Notes of the PBP, with the exception applying only to Category 15 notes. The M+C regulations at §42 CFR 422.2 define benefits using a three-prong test:

1). Health care items or services that are intended to maintain or improve the health status of enrollees,
2). The M+C organization must incur a cost or liability related to the item or service (not just an administrative cost),
3). The item or service is submitted and approved through the Adjusted Community Rate (ACR) process.

All three parts of the definition must be met for an item or service to be considered a benefit under M+C. Also, a discount is a reduction in price of an item or service where the savings is passed on to the beneficiary.

When entering cost sharing information, discounts should be entered as coinsurance and not described in the Notes. For example, if an MCO offers a discount of 20%, provided that this is a benefit with a direct cost in the ACR (not just an Admin, then the MCO should enter an 80% coinsurance in the PBP. This entry will display the appropriate information in the SB.

Maximum Enrollee Out of Pocket Costs

The Maximum Enrollee Out-of-Pocket costs are the beneficiary's maximum dollar liability amount.

Maximum Plan Benefit Coverage

Maximum Plan Benefit Coverage is only applicable for service categories where there are enhanced benefits being offered by the plan, because Medicare coverage does not allow a Maximum Plan Benefit Coverage expenditure limit.

Minimum and Maximum Cost Share Values

Throughout the PBP, minimum and maximum (min/max) cost sharing amounts are collected. Min/max cost sharing questions exist in certain categories because the cost sharing for an item or service could vary based on certain plan-specific criteria. When a min/max cost share is required, the SB sentence that is generated will display either the range of cost sharing values or the single cost share amount entered. For example, if the min/max fields are completed as $0 and $5, respectively, the SB sentence generated will read, "You pay $0 to $5 for….". If the min/max fields both contain $5, the SB sentence generated will read, "You pay $5 for….".

Optional Supplemental Step-up Benefits

If a plan offers multiple levels of a benefit, i.e., a basic benefit and an enhanced version (a.k.a. "step-up"), then information on Optional Supplemental Step-up Benefits may be entered in Section D for ten selected service categories. These ten categories contain the same data entry screens and questions as those provided in Section B.

Specifically, if an enhanced benefit is offered as an Additional or Mandatory Supplemental and also as an Optional Supplemental benefit, the Additional or Mandatory Supplemental benefit should be described in the data fields within the PBP service category in Section B. For ten selected categories, the Optional Supplemental Step-up benefit should be described entirely in Section D. For other categories, the Step-up benefit should be described in the Notes field for that service category in Section B.

NOTE: The MCO should NOT describe or enter Step-up benefits in PBP Service Categories B-13c, B-13d, or B-13e.

Example: Prescription drugs are offered as a Mandatory Supplemental benefit with a maximum limit of $500 per year. The MCO also offers Prescription Drugs as an Optional Supplemental benefit with a limit of $1500 per year. To describe these two benefits, the MCO should complete the Section B Outpatient Prescription Drug screens describing the $500 limit. The Optional Supplemental drugs benefit with a $1500 limit should be entered in Section D. Section D also collects information on packaging and pricing the Optional Supplemental benefits.

The ten Optional step-up benefit categories are:

- Chiropractic Services (7b)
- Podiatrist Services (7f)
- Transportation Services (10b)
- Outpatient Prescription Drugs (15)
- Dental - Preventative Services (16a)
- Dental - Comprehensive Services (16b)
- Vision - Eye Exams (17a)
- Vision - Eye Wear (17b)
- Hearing - Hearing Exams (18a)
- Hearing - Hearing Aids (18b)

Part A/B Plans versus Part B Only Plans

In PBP Section A, the MCO indicates the plan's Medicare beneficiary coverage criteria as either Part A/B or Part B Only. Beneficiaries who elect Medicare Part A/B coverage are entitled to Medicare-covered benefits that include Inpatient hospital, SNF, HHA, and Outpatient services. Medicare does not cover inpatient hospital and SNF services for beneficiaries who elect Part B Only coverage. Therefore, the data collected in the PBP Section B benefit categories for the Part B Only plans differs from the data collected for the Part A/B plans.

Periodicity

Periodicity within the PBP is generally presented as five or six options, including every six months, every year, every two years, etc. Although this set of options accommodates many plan benefit structures, it may not accommodate all structures. Therefore, CMS has provided for an "Other, describe" periodicity to be entered. If the benefit plan periodicity is not specifically listed, i.e., every 18 months, the option "Other, describe" should be selected and explained in the Notes. CMS has made changes in the SB sentences when the option "Other, describe" is selected so that appropriate language is provided. Please refer to the PBP-SB Crosswalk for this language.

Point-of-Service (POS)

The questions regarding whether the plan offers a point-of-service benefit are in Section B-19. This location corresponds to Health Component #19 in the ACR. This section will not be enabled if the plan type is HMO.

PPO Out-of-Network Benefits

In CY2003, Section C was used to describe a plan's

- Exclusions and restrictions of plan coverage;
- Access to providers; and
- Provision of services to dual (Medicare & Medicaid) eligible beneficiaries.

These questions were optional and not required for completion of the ACRP. Based on comments from the MCOs, these questions have been removed.

NEW FOR 2004:

Section C now contains questions that PPO plans should use to describe their Out-of Network benefits. Section C provides questions for the MCO to describe it's overall plan-level Out-of-Network benefit, detailed questions for out-of-network inpatient hospital benefits, and up to five sets of questions that can be used to describe Out-of-Network SNF and Outpatient benefits. A picklist of PBP categories (excluding Emergency Care) is provided for the MCO to select which services are included as part of the Out-of-Network benefit.

Referral versus Authorization

The question, "Is a referral required for …?" is in most service categories, and the SB sentences concerning referrals are generated from these questions. Generally, a referral is defined as an **actual** document obtained from a provider in order for the beneficiary to receive additional services, whereas authorization is defined as approval from the organization (can be verbal or

written) to receive a service. These definitions vary between organizations, so no hard and fast definition exists.

Visitor/Travel (V/T) Benefit

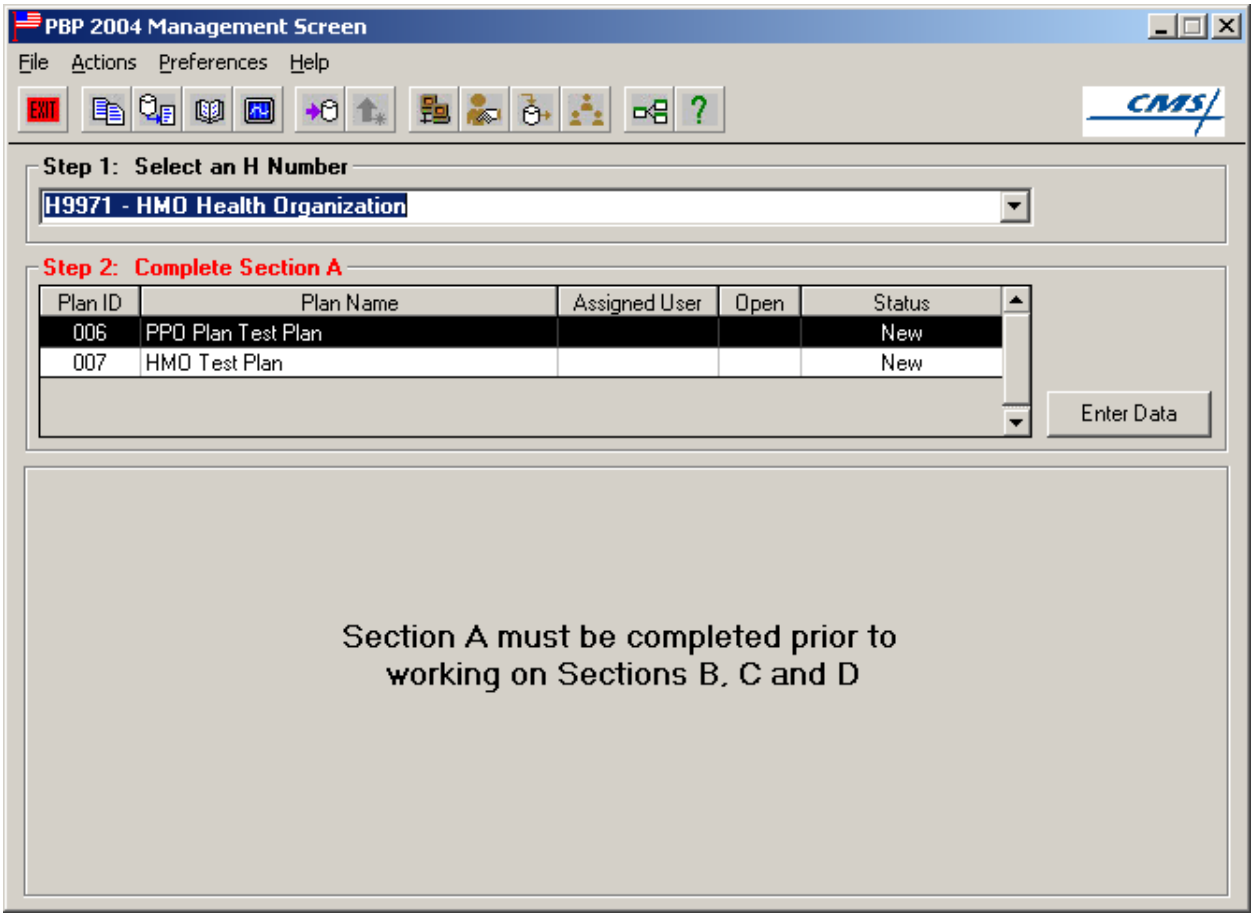
In Section A of the PBP, the plan must indicate if it includes a V/T program; and, if a V/T benefit is included, the MCO must describe the program in the V/T Notes field.

Zero Cost Share Values

If there is no cost sharing for benefits in a category, i.e., no coinsurance and no copayment, the questions "Is there an enrollee Coinsurance?" and "Is there an enrollee Copayment?" should both be answered "No". By answering "No" to both of these questions, or entering a "0" for the coinsurance and/or copayment amount, the PBP will generate the SB sentence, "There is no copayment for [particular service]".

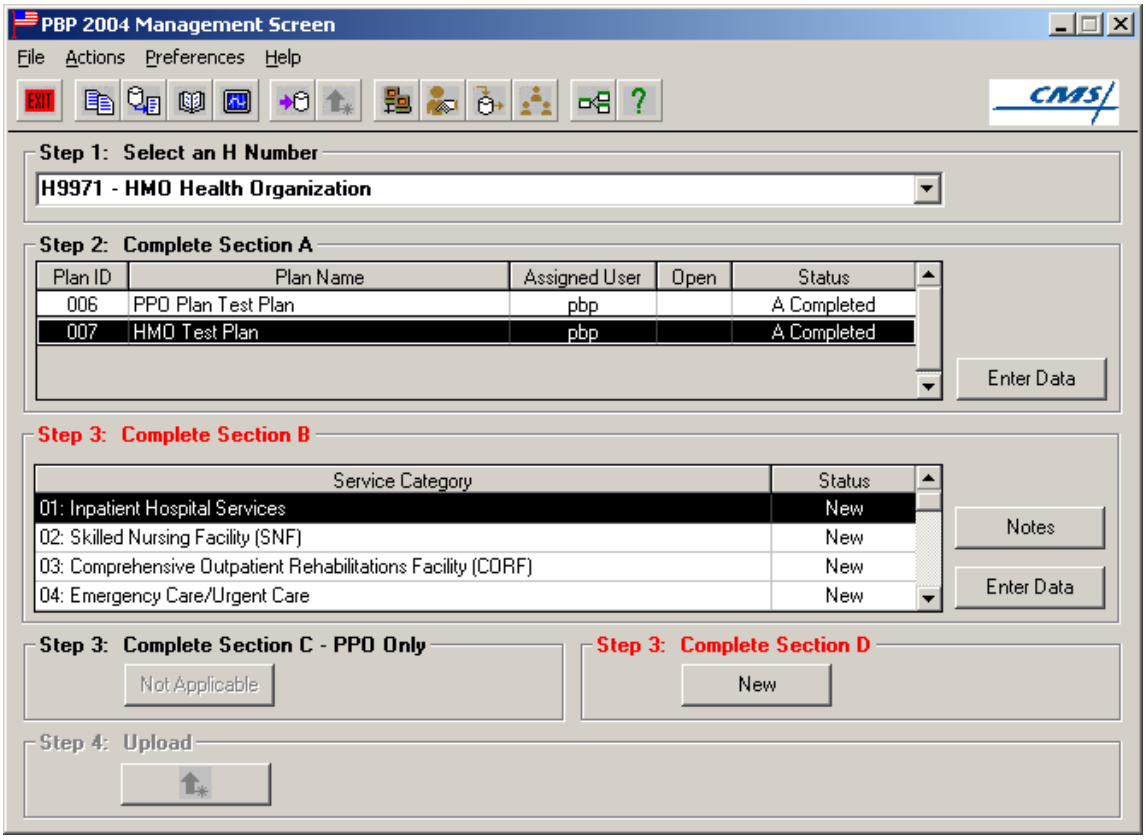
MANAGEMENT SCREEN

From the PBP 2004 Management Screen, the user can select an H Number from the Select an H Number Section. This will display the corresponding plans under the Section A area. The H Numbers and plans associated with each HITS User ID are included in the download of the PBP plan-specific information from HPMS.



Once data entry has been completed and validated for Section A, the Status displays A Completed**.** The color of the section heading *Step 2: Complete Section A* will change from **red** to **black**. Sections B, C, and D will then be enabled and displayed for data entry. As these sections are completed, the color of the section headings will also change from **red** to **black** to help indicate they are completed.

NOTE: Section C is only enabled for PPO plans.


PBP 2004 Management Screen
File Actions Preferences Help
EXIT
CMS
Step 1: Select an H Number
H9971 - HMO Health Organization
Step 2: Complete Section A
Plan ID
Plan Name
Assigned User
Open
Status
006
PPO Plan Test Plan
pbp
A Completed
007
HMO Test Plan
pbp
A Completed
Enter Data
Step 3: Complete Section B
Service Category
Status
01: Inpatient Hospital Services
New
02: Skilled Nursing Facility (SNF)
New
03: Comprehensive Outpatient Rehabilitations Facility (CORF)
New
04: Emergency Care/Urgent Care
New
Notes
Enter Data
Step 3: Complete Section C - PPO Only
Not Applicable
Step 3: Complete Section D
New
Step 4: Upload

SECTION A

Section A is where an MCO defines its plan-specific data characteristics in the PBP. Information contained in Section A consists primarily of high level MCO and Plan information, including the H number, Plan ID, type of plan, name of the plan, and geographic area of the plan. This section requires that the user enter a variety of plan characteristics that will uniquely identify the benefit packages offered by an organization. Once a plan is defined in Section A, its characteristics will correspond with subsequent data entry in Sections B, C, and D.

There are four status types available for Section A. These represent data entry progress and include:

- **New** -- Section A has not been opened for data entry.
- **Incomplete** -- Data entry has begun and has not been completed.
- **A Completed** -- Data entry has been completed for Section A.
- **Plan Completed** -- Data entry has been completed for Sections A, B, C, and D.

To begin data entry, click on <Enter Data> located to the right of Section A.

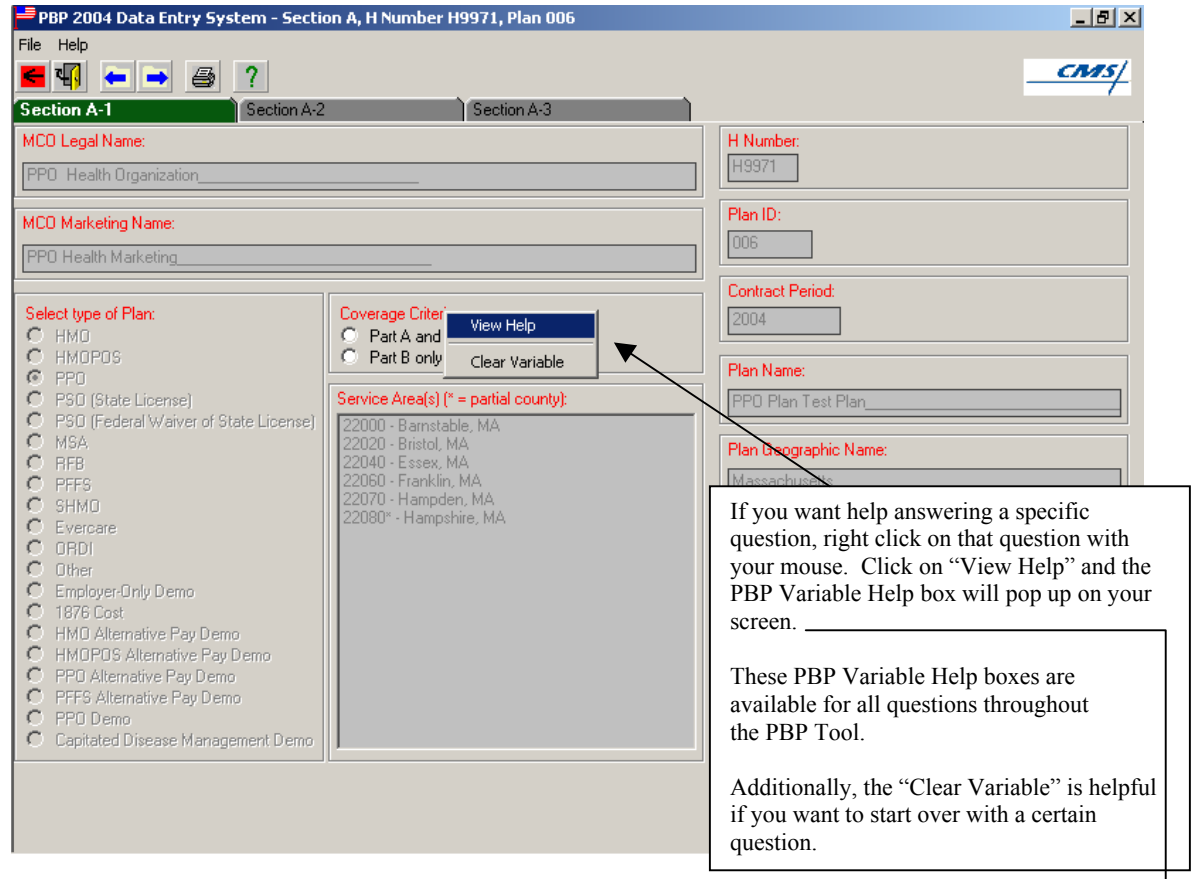
Many data elements in Section A are downloaded from HPMS after the MCO has “created” a plan and are disabled ("grayed out") in the PBP. If changes need to be made to these data, please refer to “Editing Plan Specific Information” in the Downloading chapter of these instructions. (There are several “Read Only” variables in Section A. This information is captured when an MCO completes the process for downloading the PBP software and plan specific information. These “Read Only” variables in Section A are displayed in gray and can only be updated via HPMS.)

A Service Area can represent a county in several ways. These include:

- An asterisk (*) indicates that the Service Area is for a partial county.
- [Pending] indicates that the county is pending approval.
- An asterisk (*) with [pending] indicates that a partial county is pending approval.
- [Emp-Only] indicates an Employer-Only county.

There are three questions that the MCO has to enter in Section A: Coverage criteria [Part A/B; Part B Only]; Visitor/Travel Plan (Yes/No; describe]; and Continuation area [Yes/No; describe].

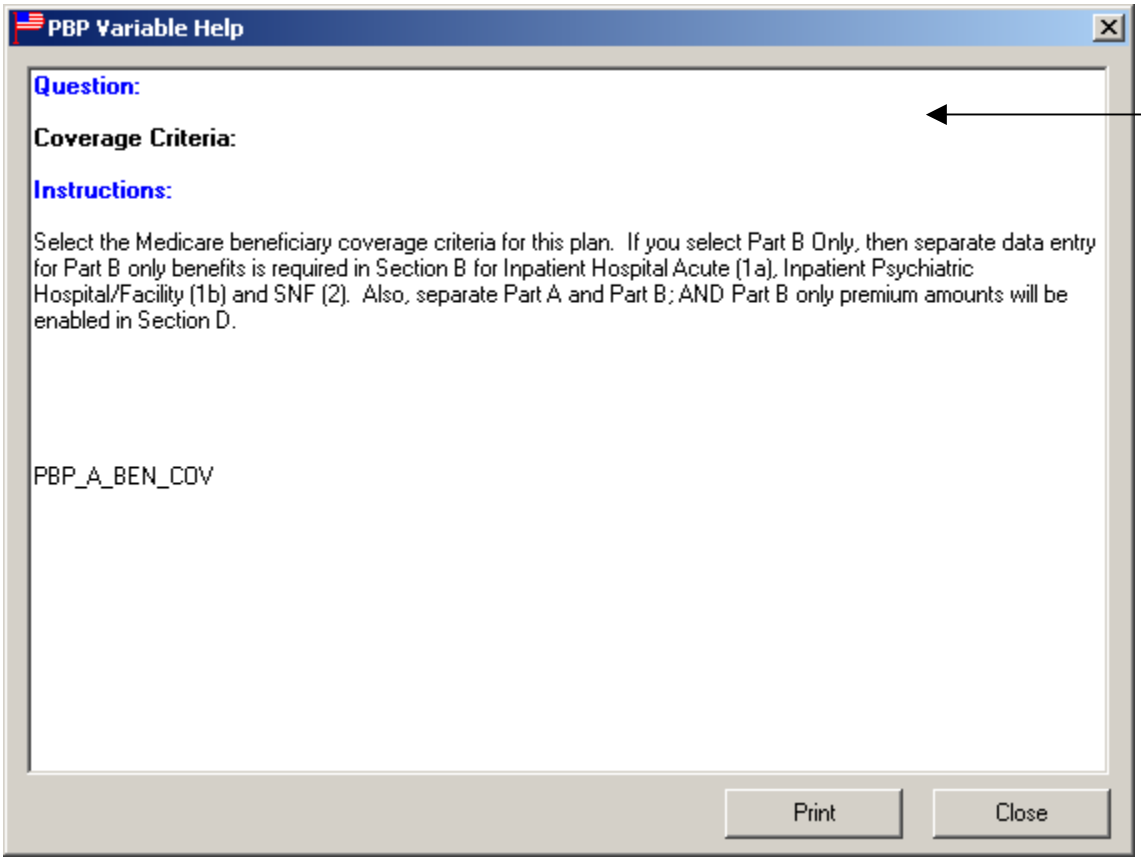
HELPFUL HINT:



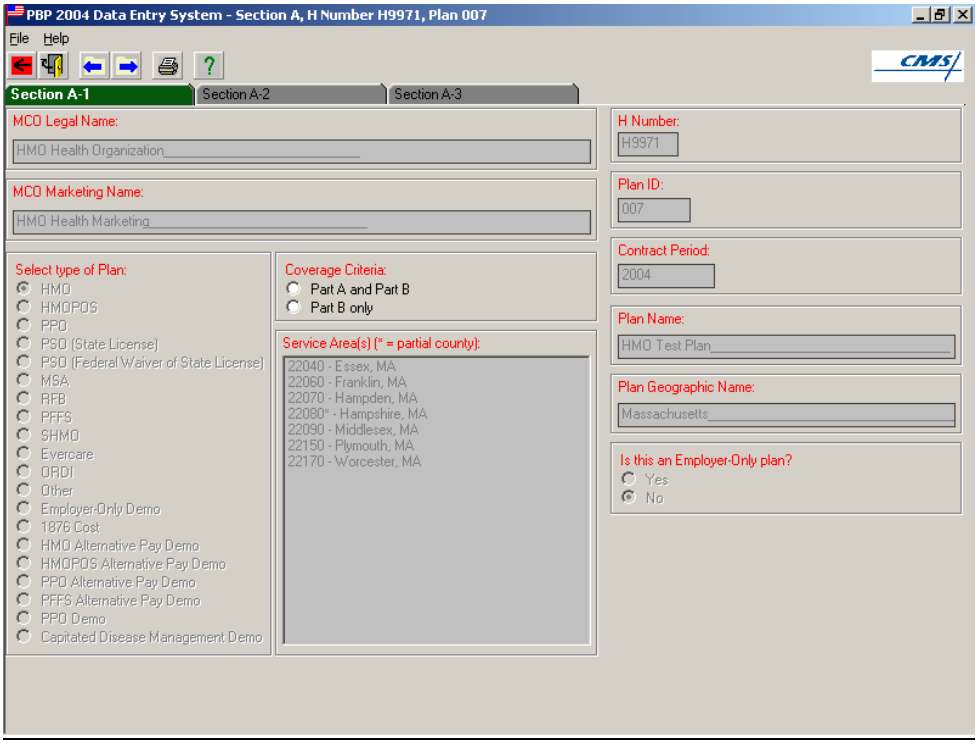
If you want help answering a specific question, right click on that question with your mouse. Click on "View Help" and the PBP Variable Help box will pop up on your screen.

These PBP Variable Help boxes are available for all questions throughout the PBP Tool.

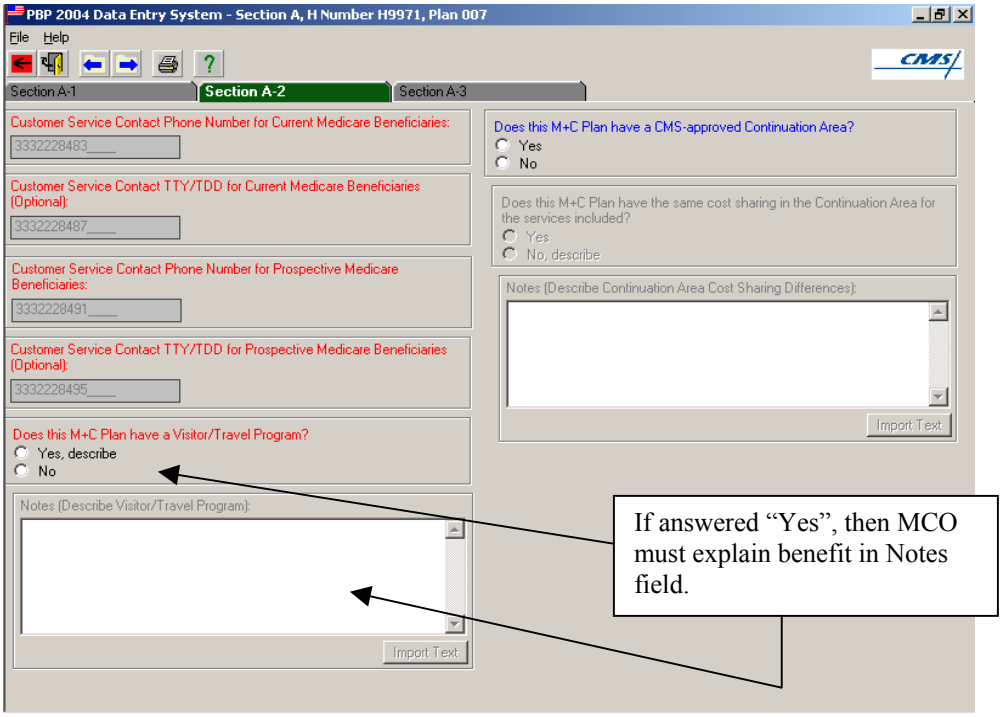
Additionally, the "Clear Variable" is helpful if you want to start over with a certain question.



Based on whether the beneficiaries to be enrolled in the plan have Part A/B coverage or Part B Only coverage, different data entry screens are enabled in Section B for Inpatient hospital and SNF benefits.



In addition, Section A-2 is where the MCO indicates and is asked to describe if the plan offers a Visitor/Travel benefit, and if the plan has an approved Continuation area in which the costs for plan benefits are the same or different. Section A-3 is an optional Notes field for the plan to enter any additional information not captured in the data entry fields pertaining to Section A.

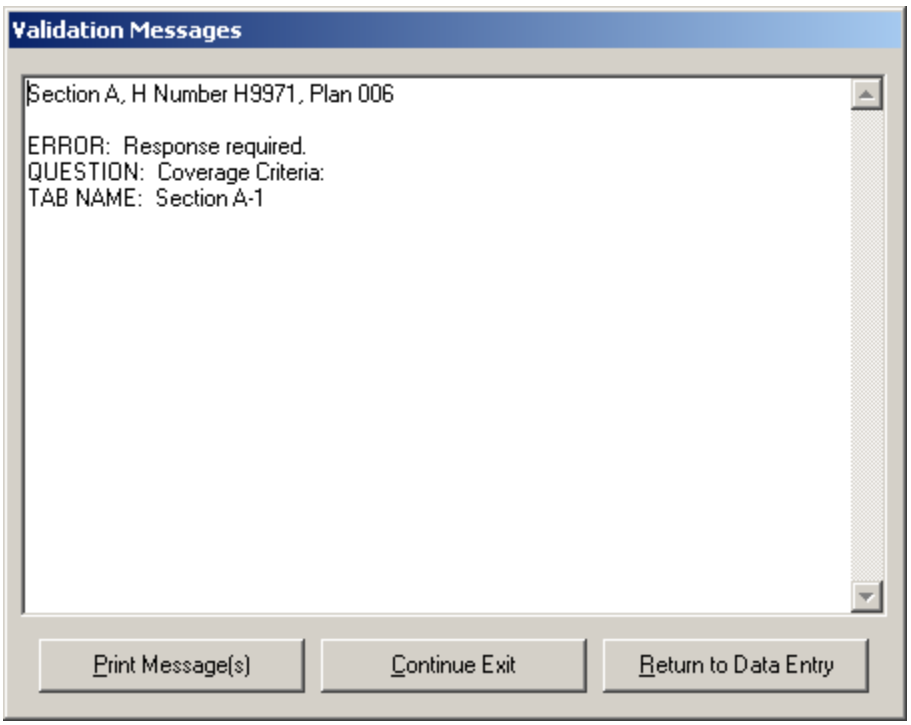


There are two exit options available when leaving data entry:

1. **Return Without Validation - -** If user exits by selecting *Return Without Validation (the yellow door)*, the system will not validate any of the rules that pertain to that section or category, and the user does not encounter warning messages alerting of invalid or missing data. This feature allows the user to exit a section quickly in the middle of data entry. If data entry has not been completed entirely for a service category, the user may wish to postpone validation until completion. The status of plans exited using *Return Without Validation* will be *Incomplete*.
2. **Return to Management Screen - -** To mark a section or service category as *Completed*, the user must use the *Return to Management Screen* option (the red arrow).

HELPFUL HINT:
When the user selects the *Return to Management Screen* option and the PBP Tool detects an unanswered question or data entry error, the Validation Message Screen will appear (as shown below). The user has the option to

- Print the message,
- Continue with the exit, ignoring the message at this time; the user will have to correct the error prior to upload,
- Return to Date Entry in order to fix the issue.



Once data entry has been completed and validated for Section A, the Status displays A Completed**.** The color of the section-heading *Step 2: Complete Section A* will change from **red** to **black**. Sections B, C, and D will then be enabled and displayed for data entry. As these sections are completed, the color of the section headings will also change from **red** to **black** to help indicate they are completed.

SECTION B

Section B collects information at the service category level on the specific benefits being offered by a plan. This information includes: benefit description; maximum plan benefit coverage; maximum enrollee out-of-pocket costs; coinsurance; deductible; copayment; authorization; and referral. An optional Notes field is also provided for the plan to enter any additional information not captured in the data entry fields.

Section B contains 19 service categories that coincide with the 18 ACR service categories and Point of-Service (POS). The 19 service categories are further disaggregated into 51 subcategories that enable an MCO to describe plan benefits in greater detail.

Table 1 displays a list of the PBP service categories with their respective Medicare and enhanced benefits.

Table 1: PBP 2004 Service Categories and Benefits

SERVICE CATEGORY #1: Inpatient Hospital Services
#1a: Inpatient Hospital Services including Acute - Medicare covered stay - Additional Days - Non-Medicare Covered Stay - Upgrades
#1b: Inpatient Psychiatric Hospital Services - Medicare covered stay - Additional Days - Non-Medicare Covered Stay - Upgrades
SERVICE CATEGORY #2: Skilled Nursing Facility (SNF)
#2: SNF - Medicare covered stay - Additional Days - Non-Medicare Covered Stay - Upgrades
SERVICE CATEGORY #3: Comprehensive Outpatient Rehabilitation Facility (CORF)
#3: CORF - Medicare covered benefits
SERVICE CATEGORY #4: Emergency Care/Post Stabilization/Urgent Care
#4a: Emergency Care - Medicare covered benefits - Worldwide care
#4b: Urgent Care - Medicare covered benefits - Worldwide care
SERVICE CATEGORY #5: Partial Hospitalization
#5: Partial Hospitalization - Medicare covered benefits
SERVICE CATEGORY #6: Home Health

#6: Home Health Services - Medicare covered benefits - Custodial care - Respite care - Homemaker services
SERVICE CATEGORY #7: Health Care Professional Services
#7a: Primary Care Physician Services - Medicare covered benefits
#7b: Chiropractic Services - Medicare covered benefits - Routine care
#7c: Occupational Therapy Services - Medicare covered benefits
#7d: Physician Specialist Services - Medicare covered benefits
#7e: Mental Health Specialty Services - Non-Physician - Medicare covered benefits
#7f: Podiatrist Services - Medicare covered benefits - Routine care
#7g: Other Health Care Professional Services - Medicare covered benefits
#7h: Psychiatric Services - Medicare covered benefits
#7i: Physical Therapy and Speech-Language Pathology Services - Medicare covered benefits
SERVICE CATEGORY #8: Outpatient Clinical/Diagnostic/Therapeutic Radiological Lab Services
#8a: Outpatient Clinical/Diagnostic/Therapeutic Radiological Lab Services - Clinical/diagnostic Medicare covered benefits - Therapeutic Medicare covered benefits
#8b: Outpatient X-Rays - Medicare covered benefits
SERVICE CATEGORY #9: Outpatient Hospital Services
#9a: Outpatient Hospital Services - Medicare covered benefits
#9b: Ambulatory Surgical Center (ASC) Services - Medicare covered benefits
#9c: Outpatient Substance Abuse Services - Medicare covered benefits
#9d: Cardiac Rehabilitation Services - Medicare covered benefits
SERVICE CATEGORY #10: Ambulance/Transportation Services
#10a: Ambulance Services - Medicare covered benefits
#10b: Transportation Services - Plan-approved / Any location
SERVICE CATEGORY #11: Durable Medical Equipment-Prosthetics, Orthotics, and Other Medical Supplies (DMEPOS)

#11a: DME - Medicare covered benefits
#11b: Medical Supplies - Medicare covered Prosthetic devices - Medicare covered Medical Supplies
#11c: Diabetes Monitoring Supplies - Medicare covered benefits
SERVICE CATEGORY #12: Renal Dialysis
#12: Renal Dialysis - Medicare covered benefits
SERVICE CATEGORY #13: Other
#13a: Outpatient Blood - Medicare covered benefits
#13b: Acupuncture - Treatments
#13c: Other1 - Service
#13d: Other2 - Service
#13e: Other3 - Service
SERVICE CATEGORY #14: Preventive Services
#14a: Health Education/Wellness Programs - Health education/Wellness - Newsletter - Nutritional Training - Smoking Cessation - Congestive Heart Program - Alternative Medicine Program - Membership in Health Club/Fitness Classes - Nursing Hotline - Disease management - Other
#14b: Immunizations - Medicare covered benefits - Hepatitis B - Other Immunizations
#14c: Routine Physical Exams - Visit
#14d: Pap Smears and Pelvic Exams Screening - Medicare covered Pap Smears - Additional Pap Smears - Medicare covered Pelvic Exams - Additional Pelvic Exams
#14e: Prostate Cancer Screening - Medicare covered benefits - Additional Screenings
#14f: Colorectal Screening - Medicare covered benefits - Additional Screenings

#14g: Bone Mass Measurement - Medicare covered benefits
#14h: Mammography Screening - Medicare covered benefits - Additional Screenings
#14i: Diabetes Monitoring - Medicare covered benefits
SERVICE CATEGORY #15: Outpatient Drugs and Biologicals/Prescription Drugs
#15: Outpatient Drugs and Biologicals/Prescription Drug - Medicare covered benefits - Drug Groups 1-5
SERVICE CATEGORY #16: Dental
#16a: Preventive Dental - Oral Exams - Prophylaxis (Cleaning) - Fluoride treatment - Dental X-rays
#16b: Comprehensive Dental - Medicare covered benefits - Emergency services - Diagnostic services - Restorative services - Endodontics/Periodontics/Extractions - Prosthodontics/Other Oral/Maxillofacial surgery/Other
SERVICE CATEGORY #17: Eye Exams/Wear
#17a: Eye Exams - Medicare covered benefits - Routine eye exams
#17b: Eye Wear - Contact lenses - Eye glasses - Lenses - Frames - Upgrades
SERVICE CATEGORY #18: Hearing Exams/Aids
#18a: Hearing Exams - Medicare covered benefits - Routine Hearing Tests - Fitting/Evaluation for Hearing Aid
#18b: Hearing Aids - All Types - Inner ear - Outer ear - Over the ear
SERVICE CATEGORY #19: Point of Service (POS)
- POS
PPO OUT-OF-NETWORK BENEFITS
- Inpatient - SNF/Outpatient 1-5

Within these service categories, four types of statutory benefit categories exist: Medicare-covered, Additional, Mandatory Supplemental, and Optional Supplemental. These are described below in greater detail.

Statutory Benefit Categories:

- ✧ Medicare-covered
  - Health services required by law
- ✧ Additional
  - Benefit provided because the plan's estimate of government payment exceeds the ACR cost of Medicare-covered benefits (dictated by adjusted excess from Worksheet E of the ACR; offering additional benefits is one of several ways to use the adjusted excess; look to your ACR instructions for further detail)
  - Plan can-not charge a premium for these benefits
  - Plan can charge cost sharing
- ✧ Mandatory Supplemental

  Non-Medicare Covered Benefits that:
  - Plan can offer, but is not required to,
  - Enrollee must buy if offered by plan
  - Plan can charge premium and/or cost sharing
- ✧ Optional Supplemental

  Non-Medicare Covered Benefits that:
  - Plan can offer, but is not required to,
  - Enrollee can buy or reject if offered by plan
  - Plan can charge premium and/or cost sharing

All supplemental benefits that were designated Optional in Section B must be associated with an Optional Benefits Package in Section D before completing a plan's PBP. In addition, Section D requests that the user define the services and premiums for both individual and grouped optional supplemental benefits. A special set of screens is provided in each Optional Supplemental Benefit package for data entry of step-up benefits for ten selected subcategories:

- 7b-Chiropractic Services,
- 7f-Podiatry Services,
- 10b-Transportation,
- 15-Outpatient Prescription Drugs,
- 16a-Preventive Dental,
- 16b-Comprehensive Dental,
- 17a-Eye Exams,
- 17b-Eye Wear,
- 18a-Hearing Exams, and
- 18b-Hearing Aids.

If a plan's optional benefits package includes a step-up benefit for which there are no special step-up screens in Section D (not one of the ten selected subcategories), these step-up benefits must be described in the corresponding Notes field of the service category in Section B.

PBP and SB

The data collected in the PBP is used to populate the sentences in the SB, which is displayed on MPPF. Table 2 displays a crosswalk between the SB Categories that display the sentences describing the benefits offered by the plan, and the PBP Service Categories that collect and provide the data. Once the PBP software has been downloaded, a more detailed copy of the PBP/SB Crosswalk is provided.

Table 2: PBP-SB 2004 Category Crosswalk
(Ordered by SB Category)

PBP		SUMMARY OF BENEFITS	
Section/ Category #	*Title*	*Category #*	*Title*
D C	Plan-level PPO Out-of-Network	1	Premium and Other Important Information
A B-1 (a-b) B-7 (b-i) B-8 (a-b) B-13b B-14 (b, d-i) B-16 (a-b) B-17 (a-b) B-18 (a-b) B-19 C	V/T benefit Inpatient Hospital Services Health Care Prof. Services Outpatient Lab, Rad., & X-ray Acupuncture Services Preventive Services Dental Services Vision Services Hearing Services POS PPO Out-of-Network	2	Doctor and Hospital Choice
B-1a C	Inpatient Hospital – Acute PPO Out-of-Network	3	Inpatient Hospital Care
B-1b C	Inpatient Psych Hospital PPO Out-of-Network	4	Inpatient Mental Health Care
B-2 C	SNF PPO Out-of-Network	5	Skilled Nursing Facility
B-6 C	Home Health Services PPO Out-of-Network	6	Home Health Care
N/A		7	Hospice
B-7a B-7d B-14c C	Primary Care Physician Svcs. Physician Specialist Svcs. Routine Physical Exams PPO Out-of-Network	8	Doctor Office Visits
B-7b C	Chiropractic Services PPO Out-of-Network	9	Chiropractic Services
B-7f C	Podiatry Services PPO Out-of-Network	10	Podiatry Services
B-7e B-7h C	Mental Health Services Psychiatric Services PPO Out-of-Network	11	Outpatient Mental Health Care
B-9c	Substance Abuse Services	12	Outpatient Substance

C	PPO Out-of-Network		Abuse Care
B-9a B-9b C	Outpatient Hospital Services ASC Services PPO Out-of-Network	13	Outpatient Services
B-10a C	Ambulance Services PPO Out-of-Network	14	Ambulance Services
B-4a	ER Care	15	Emergency Care
B-4b C	Urgent Care PPO Out-of-Network	16	Urgently Needed Care
B-7c B-7i C	Occupational Therapy PT/Speech Therapy PPO Out-of-Network	17	Outpatient Rehabilitation Services
B-11a C	DME PPO Out-of-Network	18	Durable Medical Equipment
B-11b C	Prosthetics/Orthotics PPO Out-of-Network	19	Prosthetic Devices
B-11c B-14i C	Diabetes Monitoring Supplies Diabetes Monitoring Training PPO Out-of-Network	20	Diabetes Self-Monitoring Training and Supplies
B-8a B-8b C	Outpatient Rad. & Lab Svcs. X-rays PPO Out-of-Network	21	Diagnostic Tests, X-Rays, and Lab Services
B-14b C	Bone Mass Measurement PPO Out-of-Network	22	Bone Mass Measurement
B-14f C	Colorectal Screening Exam PPO Out-of-Network	23	Colorectal Screening Exams
B-14b C	Immunizations PPO Out-of-Network	24	Immunizations
B-14h C	Mammography Screening PPO Out-of-Network	25	Mammograms (Annual Screening)
B-14d C	Pap Smears/Pelvic Exams PPO Out-of-Network	26	Pap Smears and Pelvic Exams
B-14e C	Prostate Cancer Screening PPO Out-of-Network	27	Prostate Cancer Screening Exams
B-15 C	Outpatient Prescription Drugs PPO Out-of-Network	28	Outpatient Prescription Drugs
B-16a B-16b C	Preventive Dental Comprehensive Dental PPO Out-of-Network	29	Dental Services
B-18a B-18b C	Hearing Exams Hearing Aids PPO Out-of-Network	30	Hearing Services
B-17a B-17b C	Eye Exams Eye Wear PPO Out-of-Network	31	Vision Services
B-14c C	Routine Physical Exams PPO Out-of-Network	32	Routine Physical Exams
B-14a C	Health/Wellness Education PPO Out-of-Network	33	Health/Wellness Education

B-10b C	Transportation PPO Out-of-Network	34	Transportation
B-13b C	Acupuncture PPO Out-of-Network	35	Acupuncture
B-19	POS	36	Point of Service
D	Optional Supplemental Benefit packages	Optional Benefits	Package Premium
B-7b D-Step-up 7b	Chiropractic Services (Opt.) Chiropractic Services	Optional Benefits	Chiropractic Services
B-7f D-Step-up 7f	Podiatry Services (Opt.) Podiatry Services	Optional Benefits	Podiatry Services
B-15b D-Step-up 15	Drugs (Opt.) Drugs	Optional Benefits	Outpatient Prescription Drugs
B-16a B-16b D-Step-up 16a D-Step-up 16b	Preventive Dental (Opt.) Comprehensive Dental (Opt.) Preventive Dental Comprehensive Dental	Optional Benefits	Dental
B-18a B-18b D-Step-up 18a D-Step-up 18b	Hearing Exams (Opt.) Hearing Aids (Opt.) Hearing Exams Hearing Aids	Optional Benefits	Hearing
B-17a B-17b D-Step-up 17a D-Step-up 17b	Eye Exams (Opt.) Eye Wear (Opt.) Eye Exams Eye Wear	Optional Benefits	Vision
B-10b D-Step-up 10b	Transportation (Opt.) Transportation	Optional Benefits	Transportation
B-19	POS (Opt.)	Optional Benefits	POS

NOTE: Subnetwork rules -- If the rules provided in given answers to Section B do not cover ALL Plan (network) providers, but only a portion of network providers, then provide clarification of these rules in the **Notes** field for the applicable service category. For example, if self-referral for a screening mammography is limited to a specific provider or a specific set of providers (provider networks), then provide this information in the Notes field for Mammography (14h).

The four sections of the PBP are highly interdependent; data entered into one section can impact the data entry requirements for another section. This is particularly true of Section B. For example, specifying a benefit as Optional in Section B forces the user to include that benefit in an Optional Supplemental Benefit package when filling out Section D.

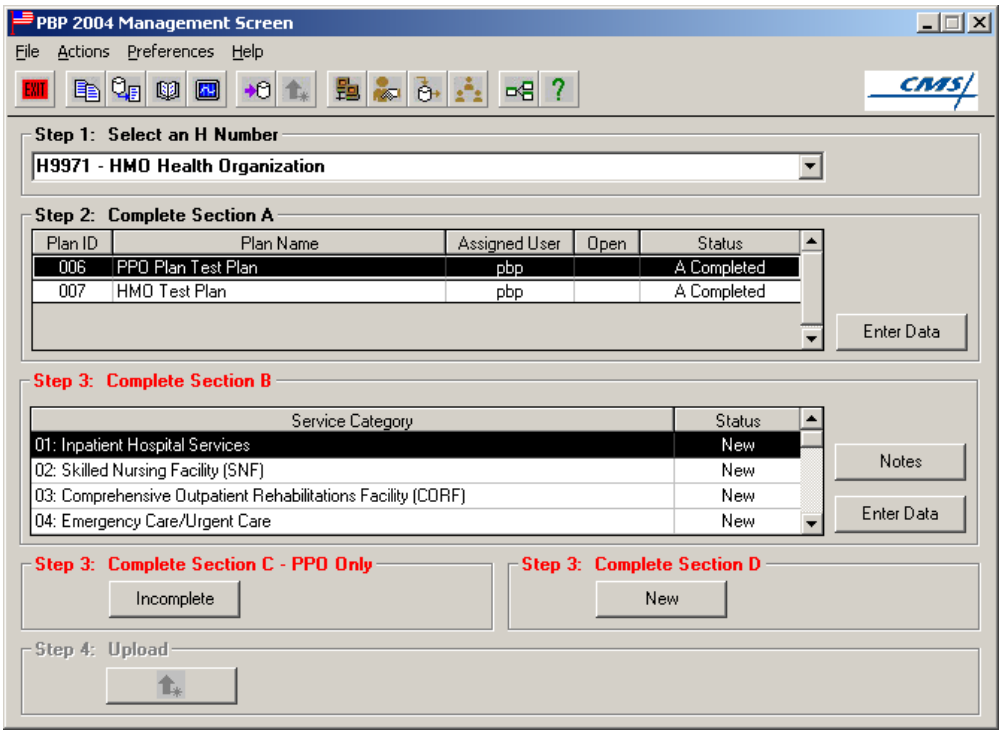
What may potentially be confusing to some users is the impact to the status of Section D when changes are made to Section B after data entry has been completed for Section D. In the above example, if data entry for Section D had previously been completed but changes are made to Section B, then the status for Section D would have automatically changed to "Incomplete". The PBP tool is designed this way in order to require the user to reopen Section D and make the necessary changes.

However, if the change to Section B had been made in error, reopening Section B and correcting the error will not automatically revert the Section D status back to "Complete". In this case, the user would have to reopen Section D and immediately exit in order to change the status back to "Complete". The reason for this is that the checks for data entry completion are only performed on the exit of a certain section or service category.

There are three status types available for **each** Service Category, B1-B19. These represent data entry progress and include:

- **New** -- Service Category has not been opened for data entry.
- **Incomplete** -- Data entry has begun and has not been completed.
- **Completed** -- Data entry has been completed.

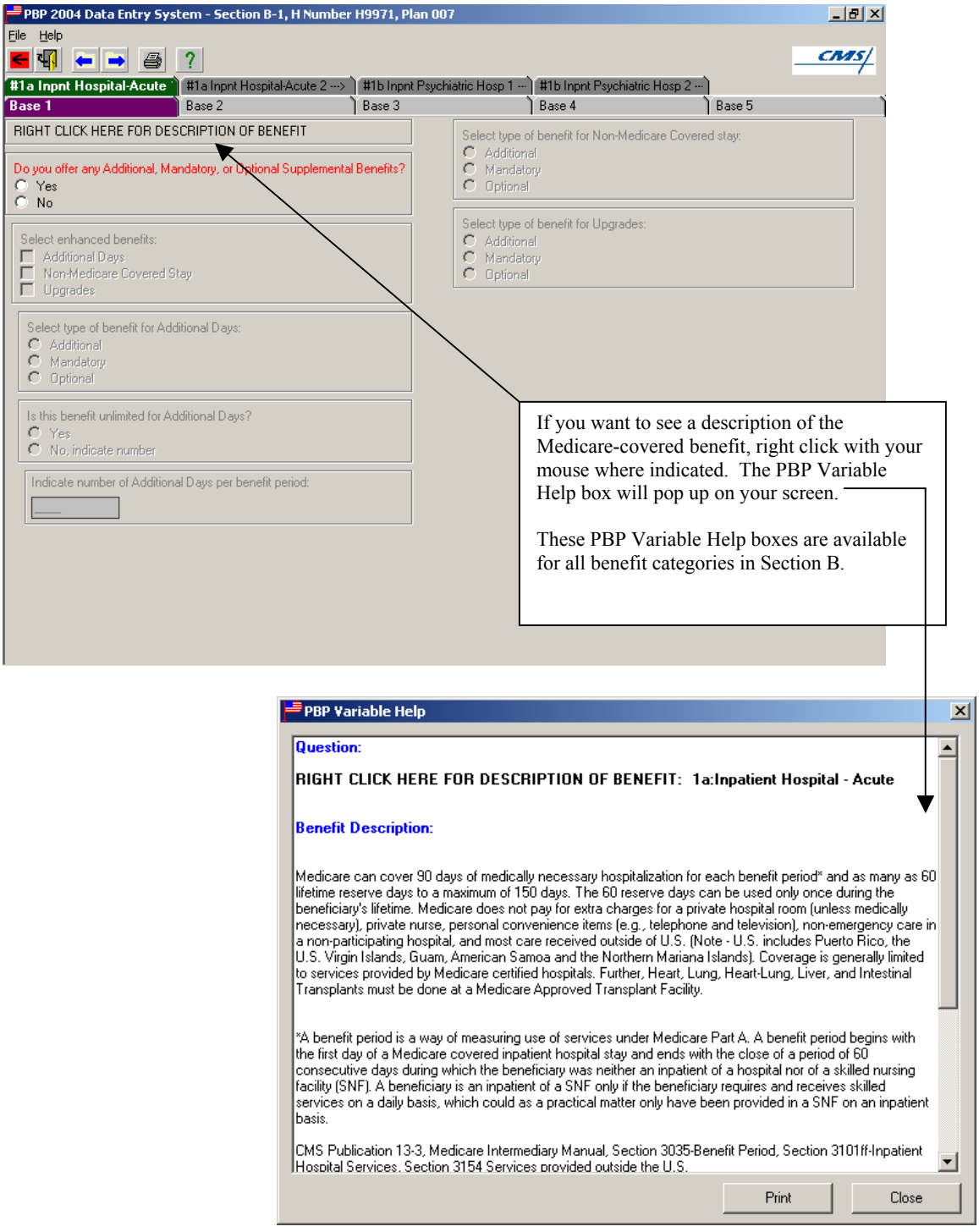
To enter notes pertaining to Section B as a whole (not service category specific), click on <Notes> located to the right of the Section B category list on the Management Screen. To begin data entry, highlight any of the Service Categories and click on <Enter Data>. See below.



Once data entry has been completed and validated for all nineteen Service Categories in Section B, the Status for each will display Completed**.** The color of the section heading *Step 3: Complete Section B* will change from **red** to **black** to help indicate Section B is completed.

NOTE: Section B is not applicable for ORDI (Office of Research, Development, and Information) plan types.

HELPFUL HINT:



SERVICE CATEGORY SPECIFIC INSTRUCTIONS

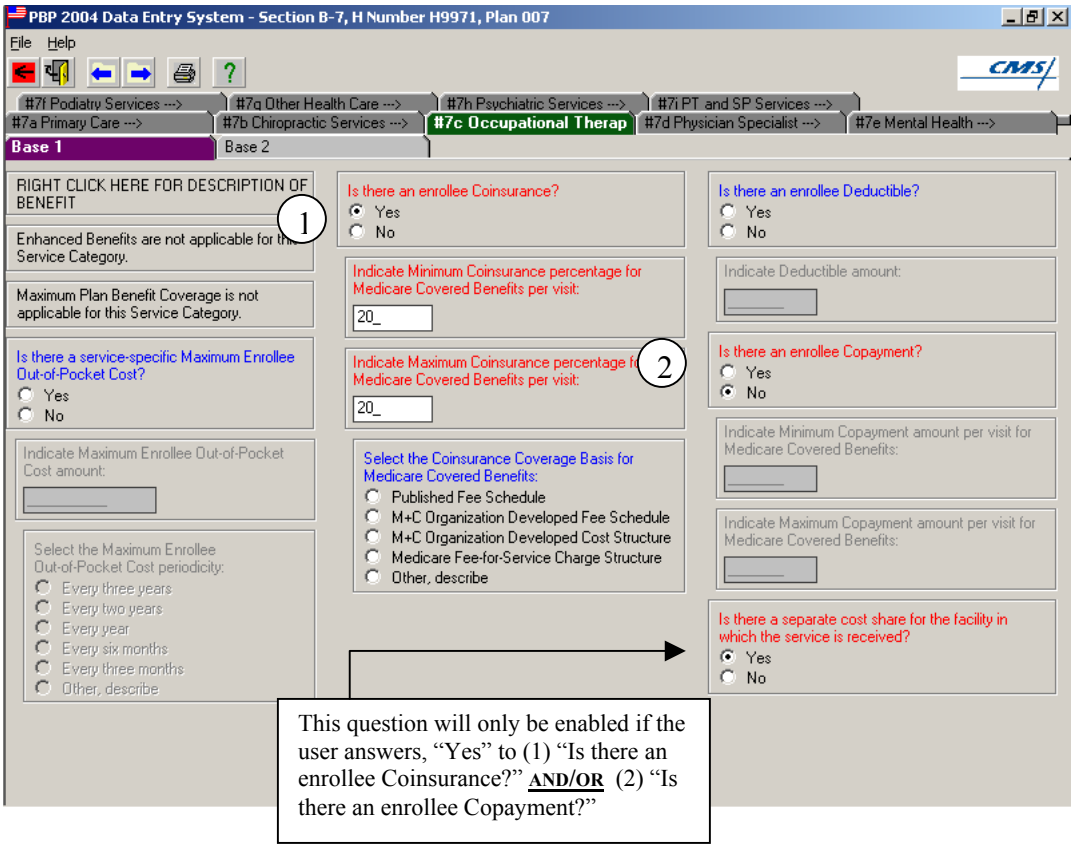
NEW FOR 2004:

For CY 2004, a new question was added to enable plans to distinguish between various tiers of cost sharing associated with different facilities. This new question: "Is there a separate cost share for the facility in which the service is received?" has been added to the following PBP categories:

7c – Occupational Therapy
7i – Physical/Speech Therapy
8a - Lab
8b – X-rays
9a – Outpatient Hospital
9b – ASC
9d – Cardiac Rehabilitation
14d – Pap/Pelvic
14e – Prostate Screening
14f – Colorectal Screening
14g – Bone Mass Measurement
14h – Screening Mammograms

The separate cost sharing information should then be described in the Notes field for that category or in the Section B Notes field on the Management Screen.

If the plan answers "Yes" to the question, then a new SB sentence is generated: "An additional cost sharing amount for the facility may apply." The sentence applies to the associated SB categories.



PBP B-1a: Inpatient Hospital—Acute

SB 3: Inpatient Hospital Services

This category collects information on Medicare-covered and non-Medicare-covered inpatient hospital – acute services.

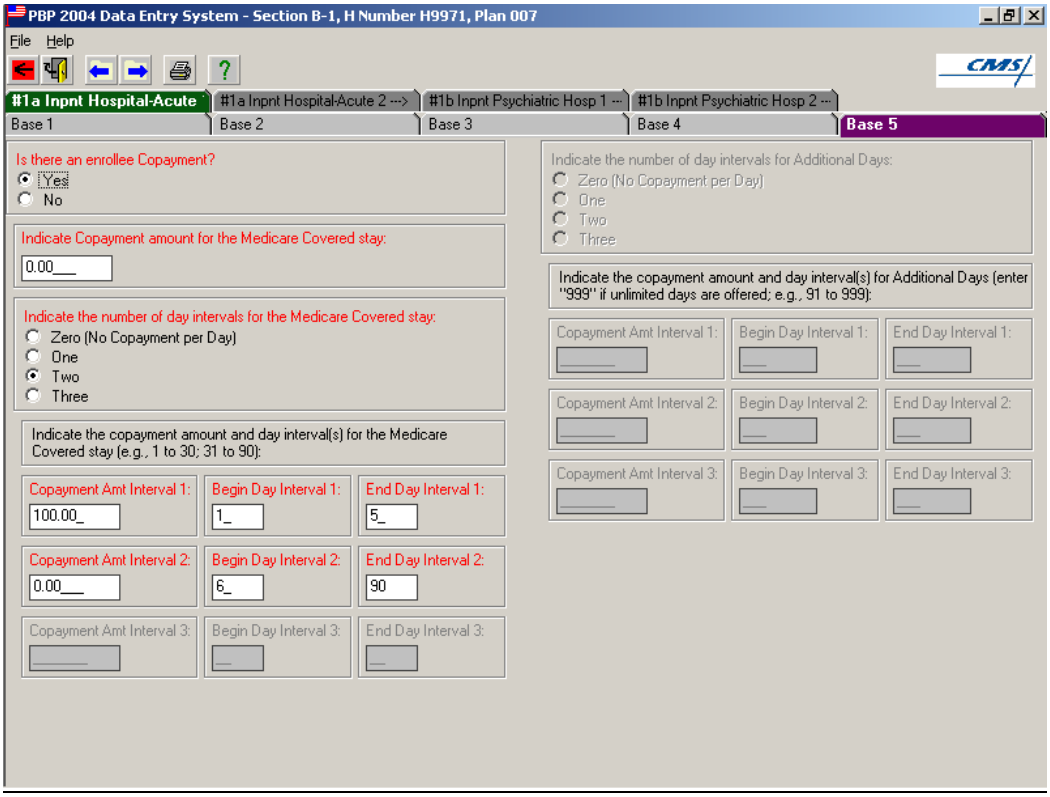
Coinsurance and copayment amounts may be entered on a per stay and/or a per day basis.

HELPFUL HINT:
In past PBP submissions, MCOs have mistakenly entered a per stay amount and a per day amount that are the same value. For example, MCOs charge $375 per stay and $375 per day for days 1-10. This means the beneficiary is charged $375 for each entry to the hospital and $375 for each day 1-10. Therefore, if a beneficiary goes to the hospital for 10 days they end up paying $4,125, or $375 + ($375*10). If an MCO intends to charge a per stay amount and a per day amount, this is fine; however, CMS has seen that this is commonly a data entry error.

Below are the instructions for entering data if a plan has cost sharing on a per day basis.

Medicare Covered Stay Cost Shares: If a plan has a per day cost structure for Medicare-covered stays, the plan must explicitly price the 90 days covered by Medicare during a benefit period. To ensure this pricing structure, the software requires the user to enter, at a minimum, a start day equal to '1' in the first interval, and an end day equal to '90' in the last interval. Note that the end day can be entered in the first, second, or third interval, depending upon the plan's cost structure.

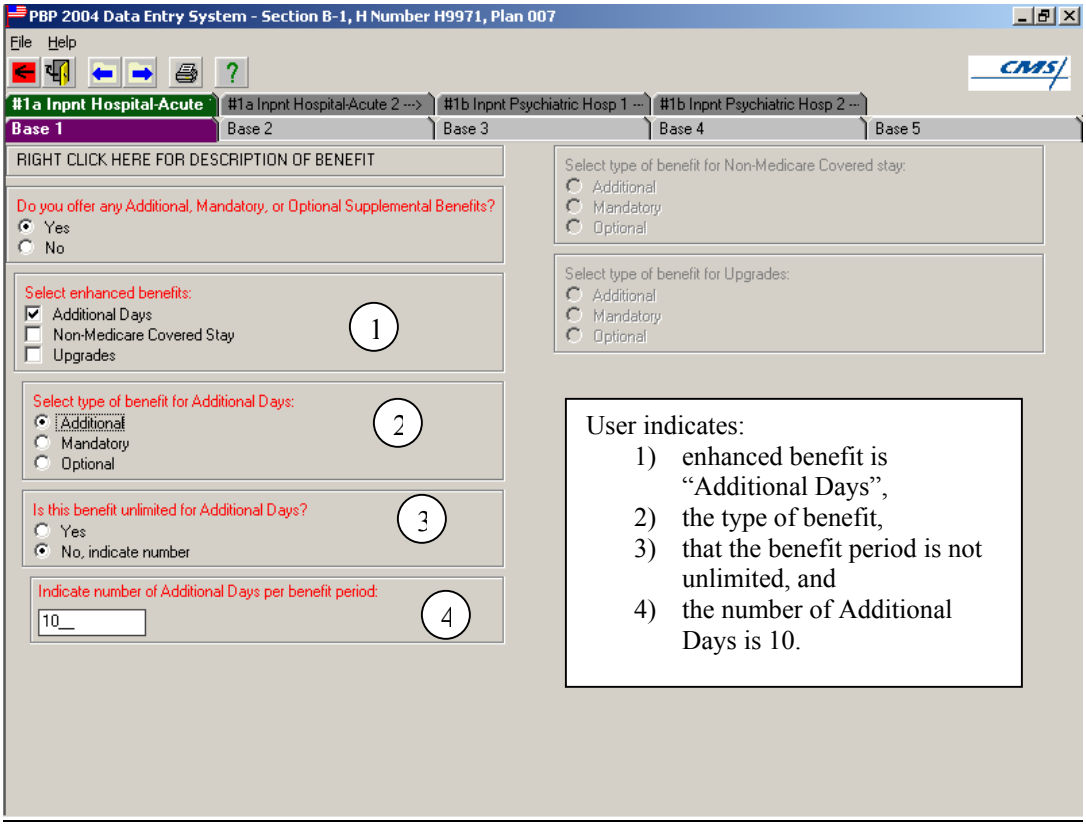
Example: If a MCO charges $0 per stay and $100 per day with a maximum of $500 per stay, the MCO should declare two intervals and enter the copayment as $100 for Days 1 through 5 and $0 for Days 6 through 90.

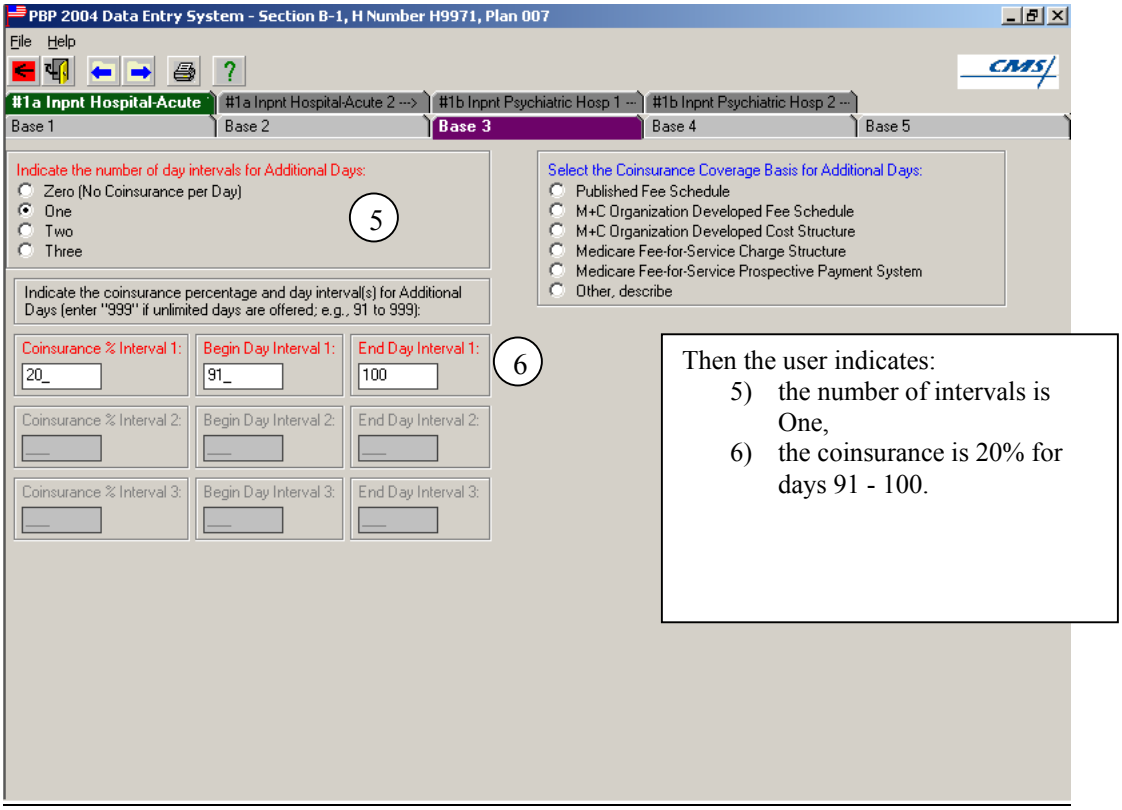


NOTE: Although Medicare FFS offers up to 60 lifetime reserve days, the payment methodology varies significantly depending upon previous use of the lifetime reserve days in and Inpatient Hospital. Days beyond the 90-day benefit period should be entered as Additional days.

Additional Days Cost Shares: Additional days are defined as days covered by the plan after the 90 Medicare-covered days per benefit period. Additional days for Inpatient Hospital Acute should always start at day 91. The number of additional days offered will determine the end day.

Example: If 10 additional days per benefit period are offered at 20% coinsurance, then the cost share structure should specify additional days 91 through 100. See below.

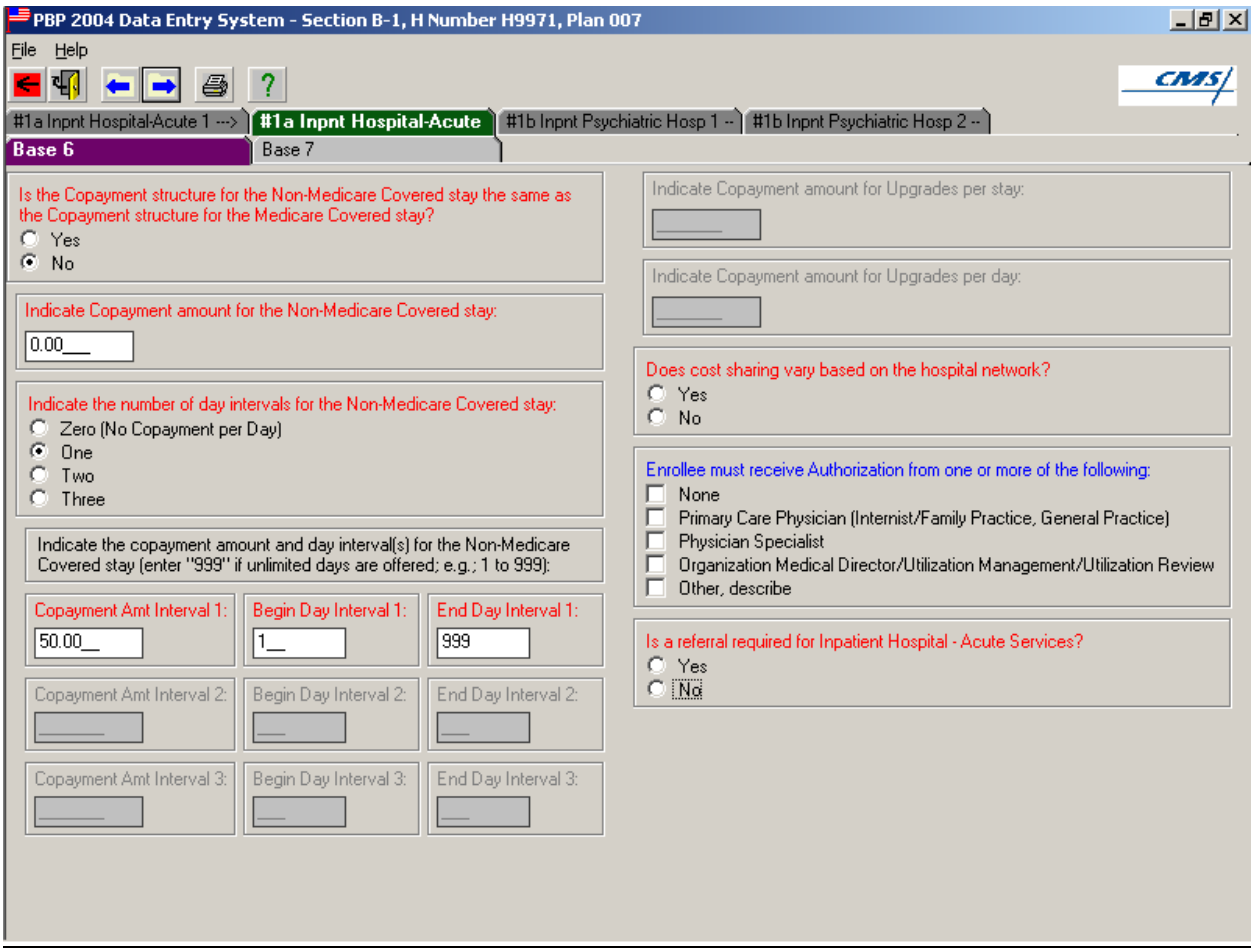




However, if an unlimited number of additional days are offered at 10% coinsurance, "999" should be used to notate the end day of the pricing structure. By using "999", the SB will generate a sentence that states "You pay $x (or x% of the cost) for additional days 91 and beyond."

Non-Medicare Covered Stay Cost Shares: A non-Medicare-covered stay is a stay that is not medically necessary and reasonable according to Medicare coverage guidelines, or is provided in a facility not certified by Medicare. If the plan has a per day cost share for the Non-Medicare-covered stay, the first day of the cost share interval must be day 1 and the last day must be the maximum number of days covered under the benefit. As in the case of the Medicare-covered stay, all days must be explicitly priced for the non-Medicare covered stay, if a per day cost share structure exists.

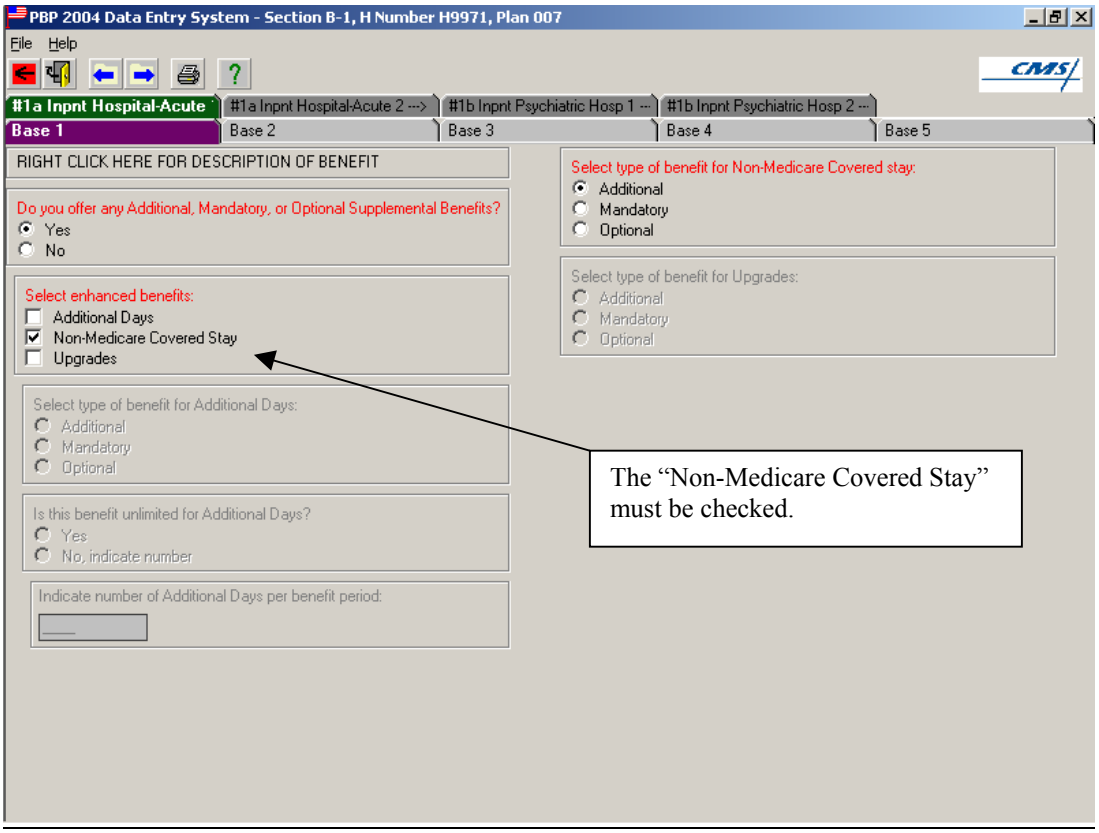
Example: If the plan charges $50 per day for an unlimited Non-Medicare-covered Stay, then the MCO should declare one interval and enter $50 for days 1 through 999.


PBP 2004 Data Entry System - Section B-1, H Number H9971, Plan 007
File
Help
CMS
#1a Inpnt Hospital-Acute 1 --->
#1a Inpnt Hospital-Acute
#1b Inpnt Psychiatric Hosp 1 --
#1b Inpnt Psychiatric Hosp 2 --
Base 6
Base 7
Is the Copayment structure for the Non-Medicare Covered stay the same as the Copayment structure for the Medicare Covered stay?
Yes
No
Indicate Copayment amount for the Non-Medicare Covered stay:
0.00
Indicate the number of day intervals for the Non-Medicare Covered stay:
Zero (No Copayment per Day)
One
Two
Three
Indicate the copayment amount and day interval(s) for the Non-Medicare Covered stay (enter "999" if unlimited days are offered; e.g.; 1 to 999):
Copayment Amt Interval 1:
50.00
Begin Day Interval 1:
1
End Day Interval 1:
999
Copayment Amt Interval 2:
Begin Day Interval 2:
End Day Interval 2:
Copayment Amt Interval 3:
Begin Day Interval 3:
End Day Interval 3:
Indicate Copayment amount for Upgrades per stay:
Indicate Copayment amount for Upgrades per day:
Does cost sharing vary based on the hospital network?
Yes
No
Enrollee must receive Authorization from one or more of the following:
None
Primary Care Physician (Internist/Family Practice, General Practice)
Physician Specialist
Organization Medical Director/Utilization Management/Utilization Review
Other, describe
Is a referral required for Inpatient Hospital - Acute Services?
Yes
No

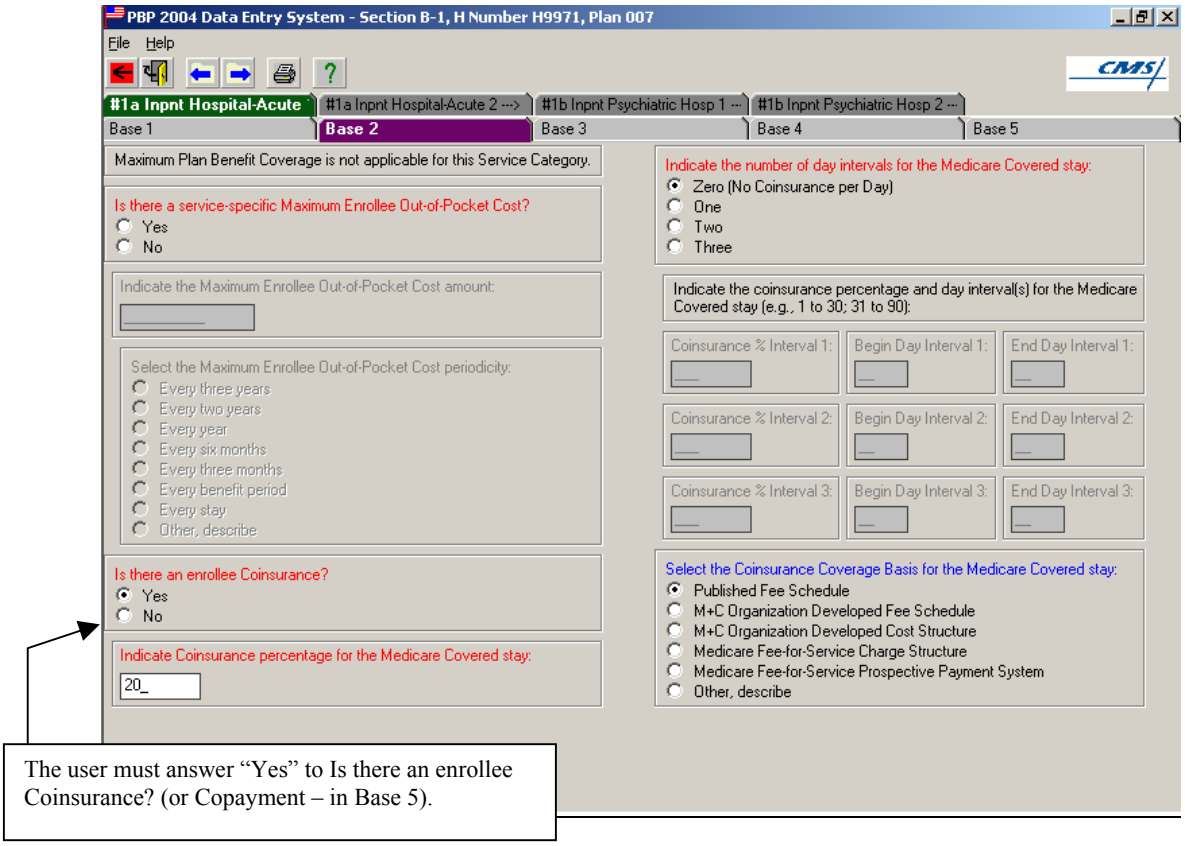
HELPFUL HINT:

If the Medicare Covered cost-sharing and Non-Medicare Covered cost sharing are the same, answer "Yes" to the question, "Is the Copayment [Coinsurance] structure for the Non-Medicare Covered stay the same as the Copayment [Coinsurance] structure for the Medicare Covered stay?" By answering, "Yes", the correct SB sentences will be produced, eliminating unneeded duplication of sentences. In order to enable this question, see the PBP screen shots below:

Step 1:

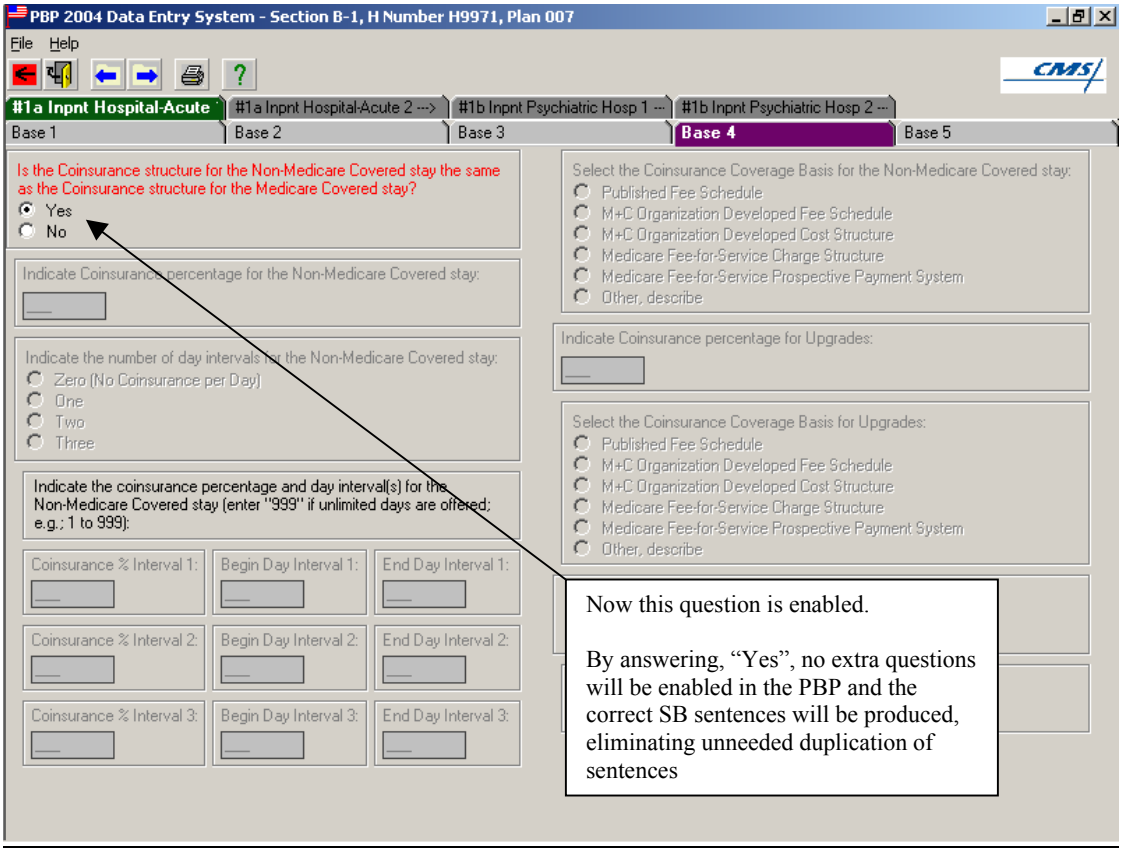


Step 2:



The user must answer "Yes" to Is there an enrollee Coinsurance? (or Copayment – in Base 5).

Step 3:

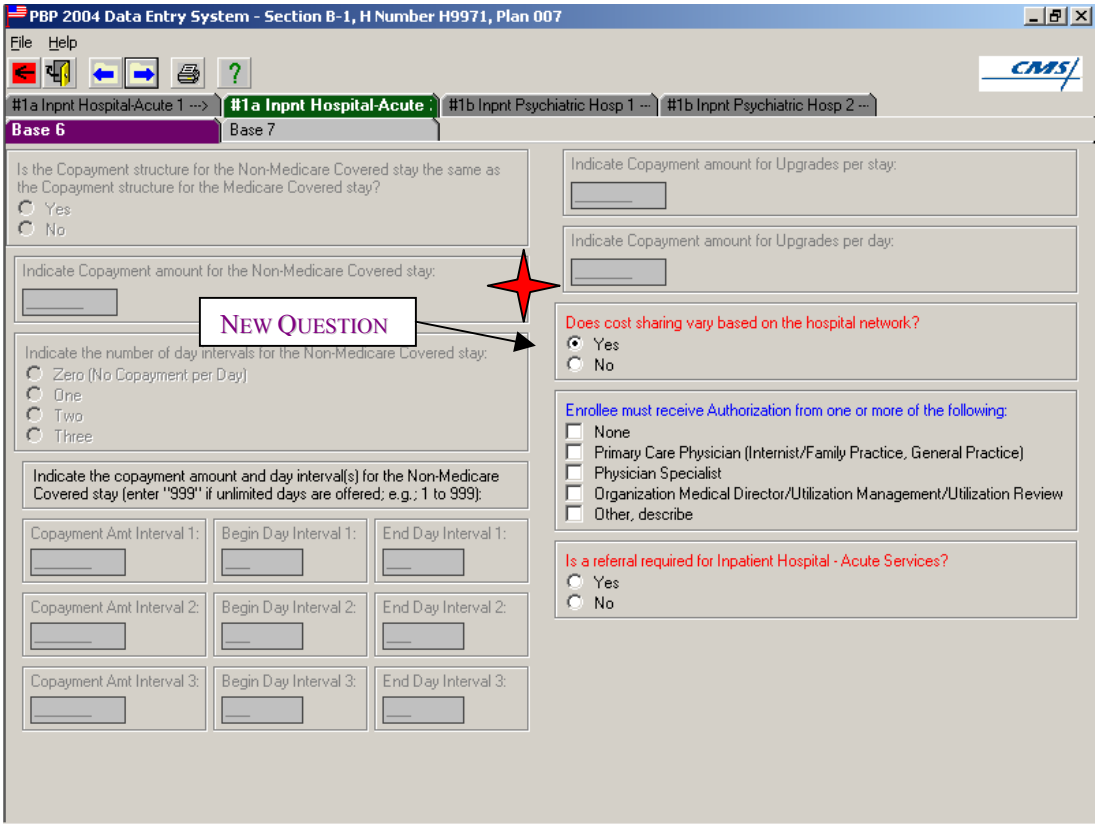


Now this question is enabled.

By answering, "Yes", no extra questions will be enabled in the PBP and the correct SB sentences will be produced, eliminating unneeded duplication of sentences

NEW FOR 2004:

For CY 2004, a new question was added to the Inpatient Hospital categories to enable plans to distinguish between various tiers of cost sharing associated with different hospitals. If the MCO answers "Yes" to this question, the MCO should describe the cost sharing design based on the hospital network in the service category Notes. A general SB sentence will generate that says, "Cost sharing may vary for each Medicare-covered stay according to the hospital in which services are received."



General issue concerning Inpatient Substance Abuse: Inpatient Substance Abuse may be covered either under Inpatient Hospital Acute or Inpatient Psychiatric Hospital. The MCO may use either subcategory to describe it in the PBP.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for Inpatient Hospital out-of-network benefits.

PBP B-1b: Inpatient Psychiatric Hospital

SB 4: Inpatient Mental Health Services

This category collects information on Medicare-covered and non-Medicare-covered inpatient psychiatric hospital services.

See above Section "PBP B-1a: Inpatient Hospital—Acute SB 3: Inpatient Hospital Services" for more detailed information that also pertains to "PBP B-1b: Inpatient Psychiatric Hospital SB 4: Inpatient Mental Health Services."

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for Inpatient Psychiatric Hospital out-of-network benefits.

PBP B-2: Skilled Nursing Facility (SNF)

SB 5: SNF Services

This category collects information on Medicare-covered and non-Medicare-covered SNF services.

Coinsurance and copayment amounts may be entered on a per stay and/or a per day basis. Below are the instructions for entering data if a plan has cost sharing on a per day basis.

Medicare Covered Stay Cost Shares: If a plan has a per day cost structure for Medicare-covered stays, the plan must explicitly price the 100 days covered by Medicare during a benefit period. To ensure this pricing structure, the software requires the user to enter, at a minimum, a start day equal to '1' in the first interval, and an end day equal to '100' in the last interval. Note that the end day can be entered in the first, second, or third interval, depending upon the plan's cost structure.

Additional Days Cost Shares: Additional days are defined to be days covered after the 100 Medicare-covered days per benefit period. Additional days for SNF should always start at day 101. The number of additional days offered will determine the end day.

Non-Medicare Covered Stay Cost Shares: A non-Medicare-covered stay is not medically necessary and reasonable according to Medicare coverage guidelines, or is provided in a facility not certified by Medicare. If the plan has a per day cost share for the Non-Medicare-covered stay, the first day of the cost share interval must be day 1 and the last day must be the maximum number of days covered under the benefit. As in the case of the Medicare-covered stay, all days must be explicitly priced for the non-Medicare covered stay, if a per day pricing structure exists.

HELPFUL HINT:
See above Section "PBP B-1a: Inpatient Hospital—Acute SB 3: Inpatient Hospital Services" for more detailed information concerning 2 helpful hints that also apply to SNF.

General issue concerning Skilled Nursing Facility: Medicare requires a prior 3-day inpatient hospital stay and an admission to a SNF within 30 days of the inpatient discharge, to be a qualifying SNF stay. If the MCO admits a beneficiary who does not meet these requirements to a SNF, it is a non-Medicare covered SNF stay and must be described and priced accordingly in the PBP and ACR as an Additional, Mandatory or Optional Supplemental benefit.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for SNF out-of-network benefits.

PBP B-3: Comprehensive Outpatient Rehabilitation Facility (CORF)

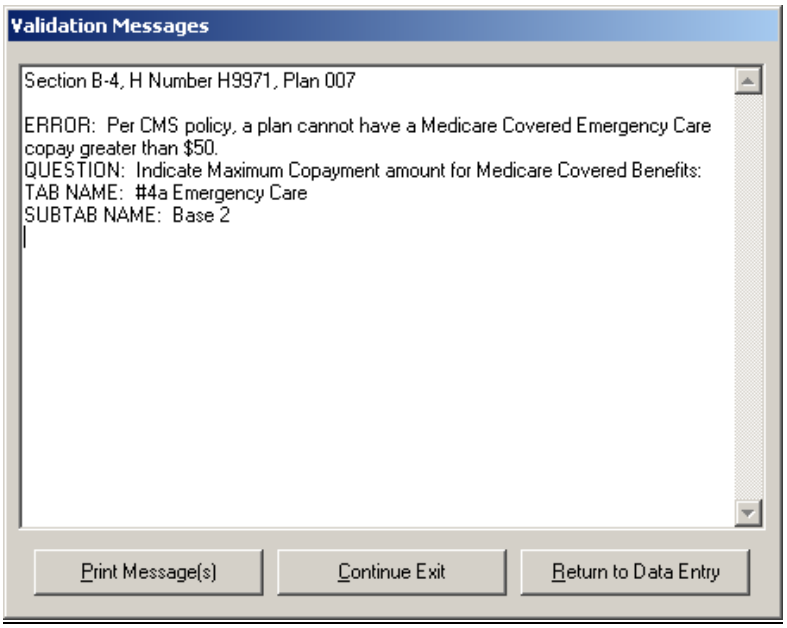
This category collects information on Medicare-covered services provided at a comprehensive outpatient rehabilitation facility.

PBP B-4a: Emergency Care/Post Stabilization Care

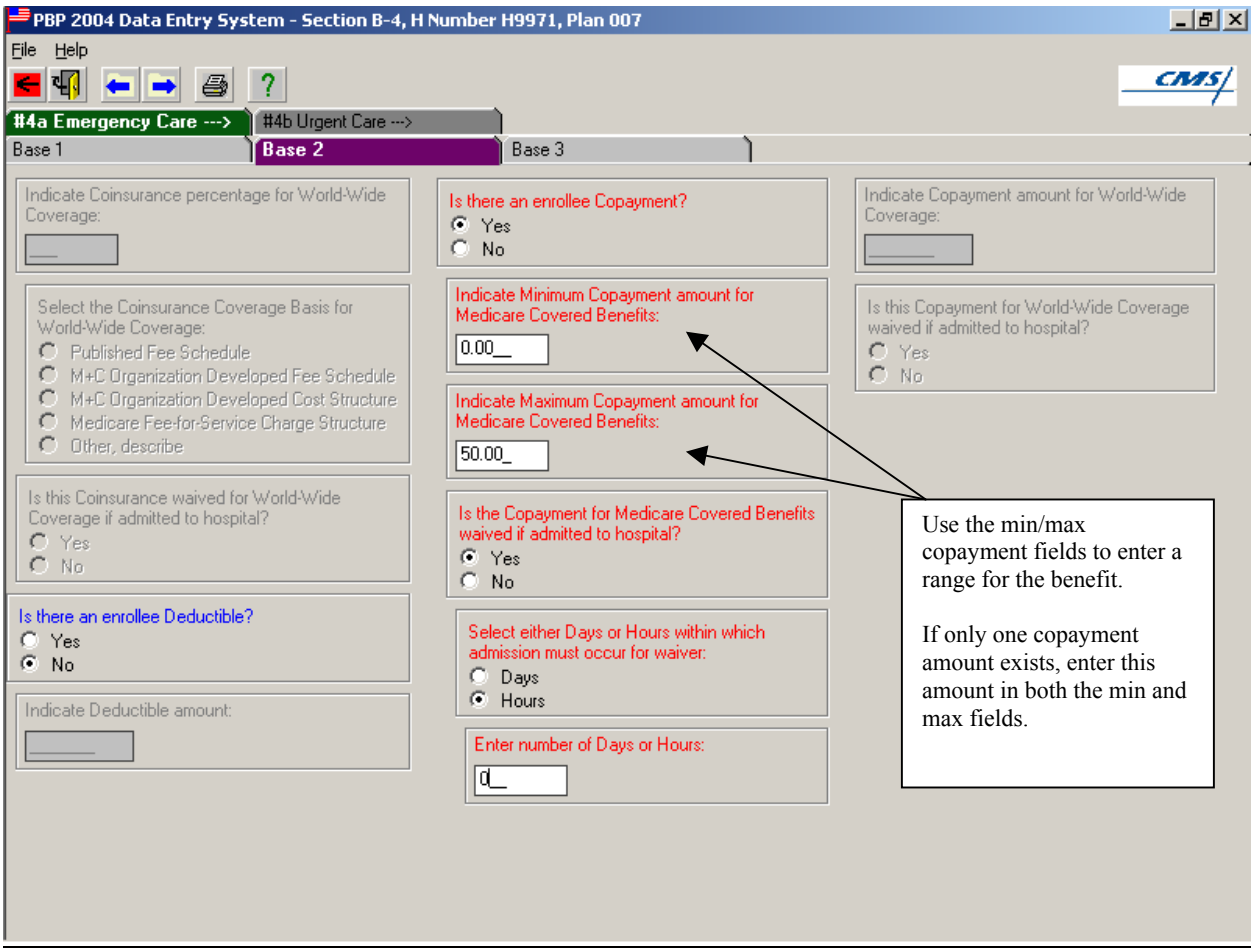
SB 15: Emergency Care

This category collects information on Medicare-covered and non-Medicare-covered emergency room services.

HELPFUL HINT:
The edit rule limiting the cost share for an ER visit to $50 has been reinstated for CY2004. Also, the SB sentence for the ER cost share has been revised to reflect this limit if a coinsurance is charged. If a value greater the $50 is entered, the following validation screen will appear:



HELPFUL HINT:
MCOs often waive the coinsurance and/or copayment for the emergency room visit if a beneficiary is admitted to the hospital. If the cost share is waived, the question "Is the Coinsurance [Copayment] for Medicare Covered Benefits waived if admitted to hospital?" should be answered "Yes" and the appropriate days or hours in which the admission must occur for the waiver should be entered. If the waiver is only applicable when the beneficiary is immediately admitted to the hospital, then "hours" should be selected and the number "0" should be entered as the number of hours in which admittance must occur for the cost sharing to be waived. This will produce the sentence, "You do not pay this amount if you are immediately admitted to the hospital." See example below.



Emergency Care is not available in the Section C PPO Out-of-Network benefits list, so there are no SB Out-of-Network sentences for PPOs for this category. Under current statutory regulations, an MCO cannot charge more for out of network Emergency services than in network.

PBP B-4b: Urgently Needed Care/Urgent Care Centers

SB 16: Urgently Needed Care

This category collects information on Medicare-covered and non-Medicare-covered urgent care services.

HELPFUL HINT:
Urgent care received in network by a contracted physician/hospital should be entered in this section. Urgent care received out of network by a non-contracted physician/hospital should be entered in Section C.

HELPFUL HINT:
See "PBP B-4a: Emergency Care/Post Stabilization Care, SB 15: Emergency Care" for more detailed information regarding the question "Is the Coinsurance [Copayment] for Medicare Covered Benefits waived if admitted to hospital?".

Urgent Care is available in the Section C PPO Out-of-Network benefits list, so there are SB Out-of-Network sentences for PPOs for this category.

PBP B-5: Partial Hospitalization

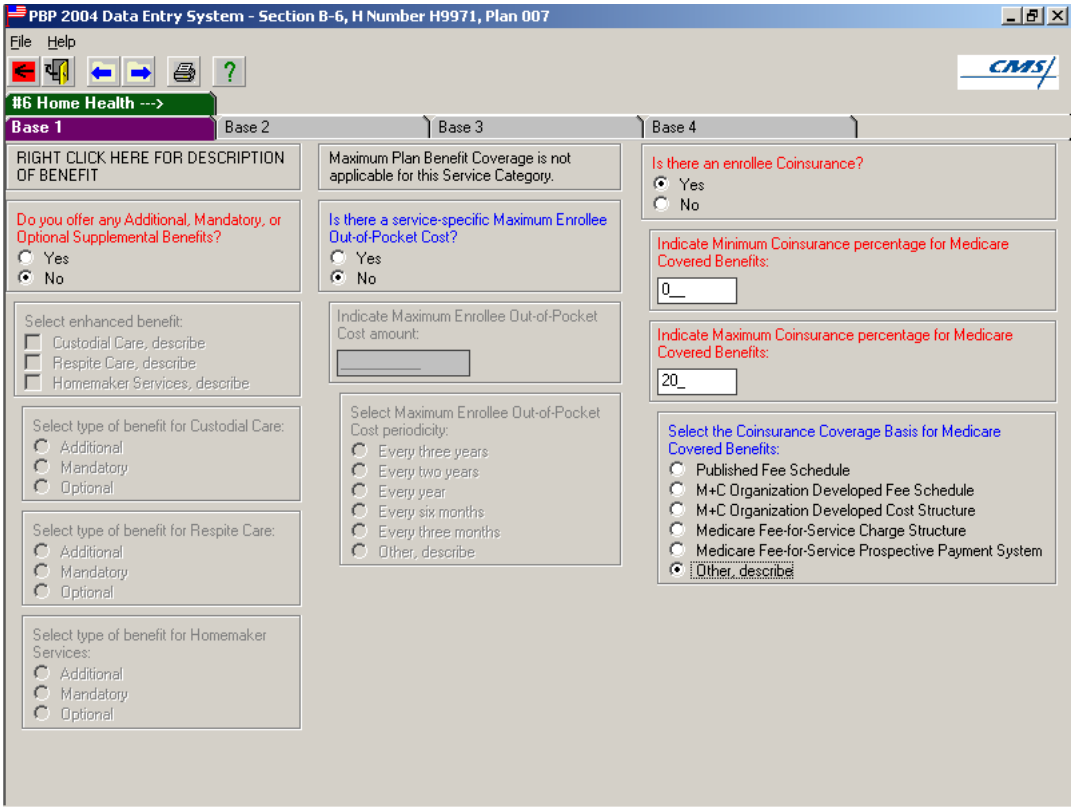
This category collects information on Medicare-covered partial hospitalization services. There are no SB sentences associated with this category.

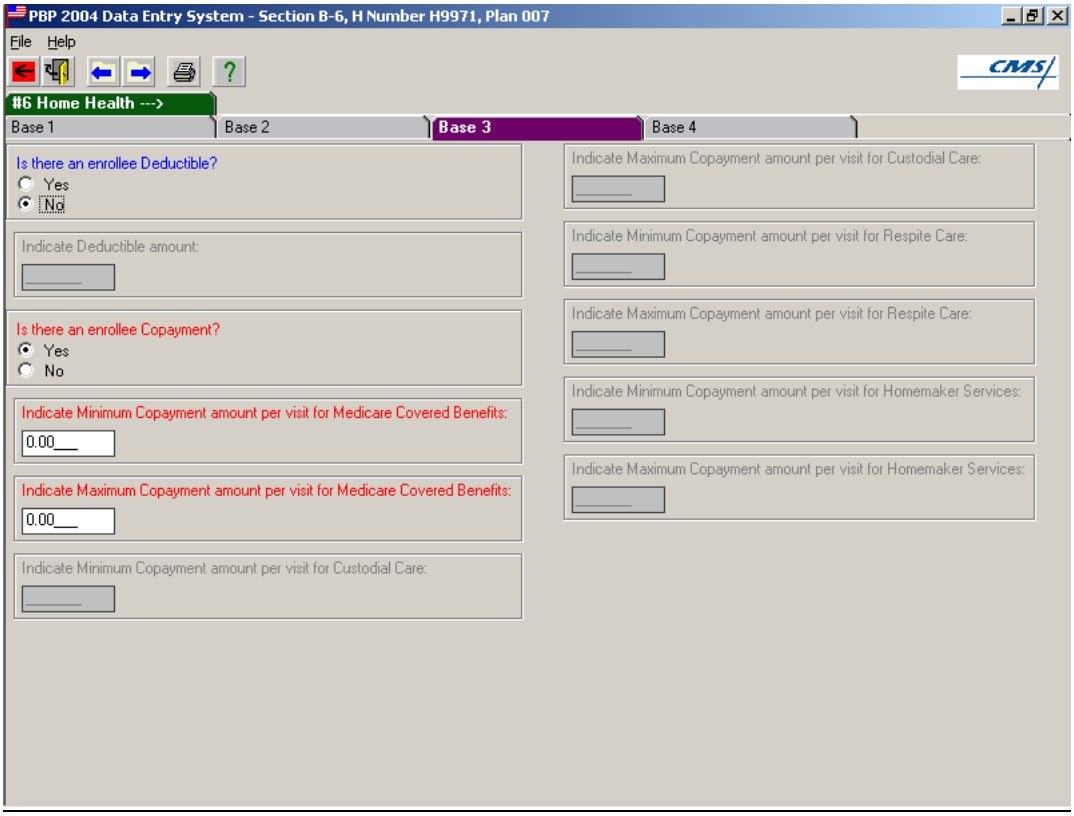
PBP B-6: Home Health Services

SB 6: Home Health Care

This category collects information on Medicare-covered and non-Medicare-covered home health services.

HELPFUL HINT:
Currently if an MCO wants to offer a $0 copay or 20% of the cost for a Medicare covered service, the information must be entered as shown below. The SB will only print copay values greater than $0 for this service. However, by following the example below, the SB will read, "You pay 0% - 20% of the cost for Medicare-covered Home Health visits." (**NOTE:** CMS will look into improving this language for 2005.)





SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-7a: Primary Care Physician Services

SB 8: Doctor Office Visits

This category collects information on Medicare-covered primary care physician services.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-7b: Chiropractic Services

SB 9: Chiropractic Services

This category collects information on Medicare-covered and non-Medicare-covered chiropractic services.

Medicare covered chiropractic services only include Manual Manipulation of the Spine to Correct Subluxation. Any other chiropractic services that are offered, such as routine care, would be classified as either Additional, Mandatory Supplemental, or Optional Supplemental benefits.

In the SB, Manual Manipulation of the Spine and Chiropractic Services (Routine care) are merged into one category, "Chiropractic Services". The SB sentences will continue to distinguish between the Manual Manipulation of the Spine and Routine Care.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-7c: Occupational Therapy Services

SB 17: Outpatient Rehabilitation Services

This category collects information on Medicare-covered occupational therapy services.

NEW FOR 2004:
See Section B above for more detailed information regarding the facility cost sharing question.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-7d: Physician Specialist Services

SB 8: Doctor Office Visits

This category collects information on Medicare-covered specialist services.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-7e: Mental Health Specialist Services

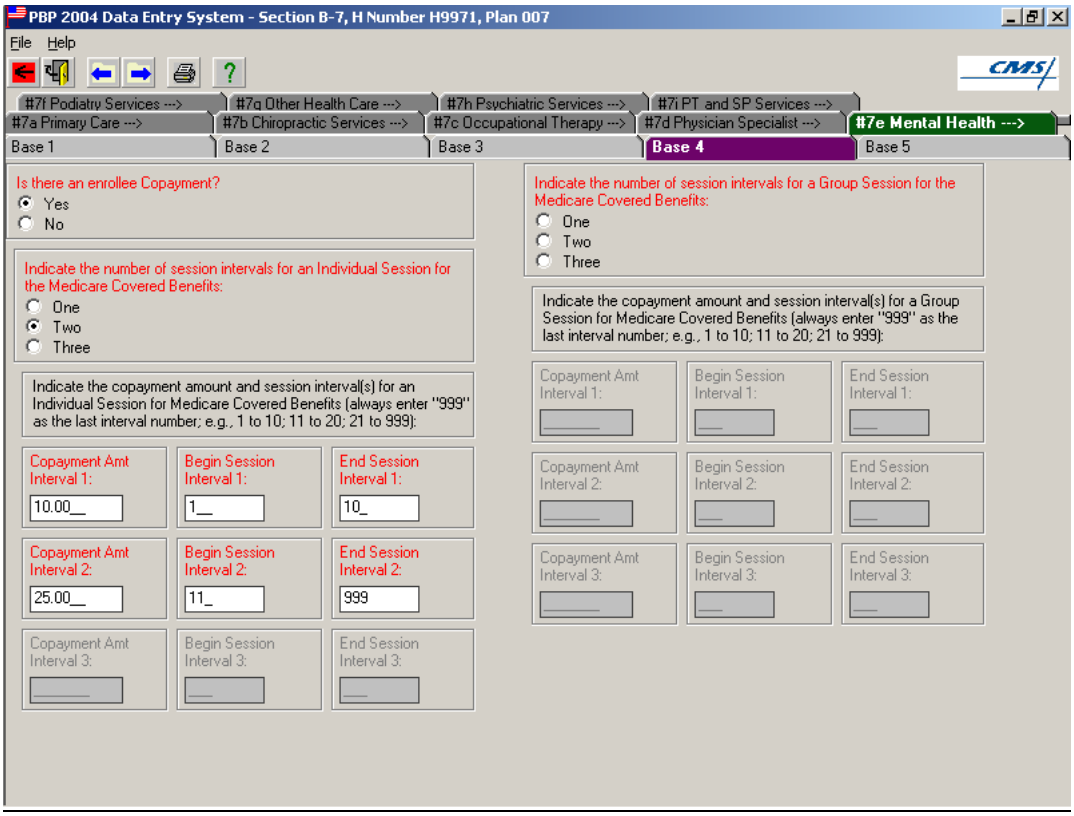
SB 11: Outpatient Mental Health Care

This category collects information on Medicare-covered mental health services, excluding psychiatric services.

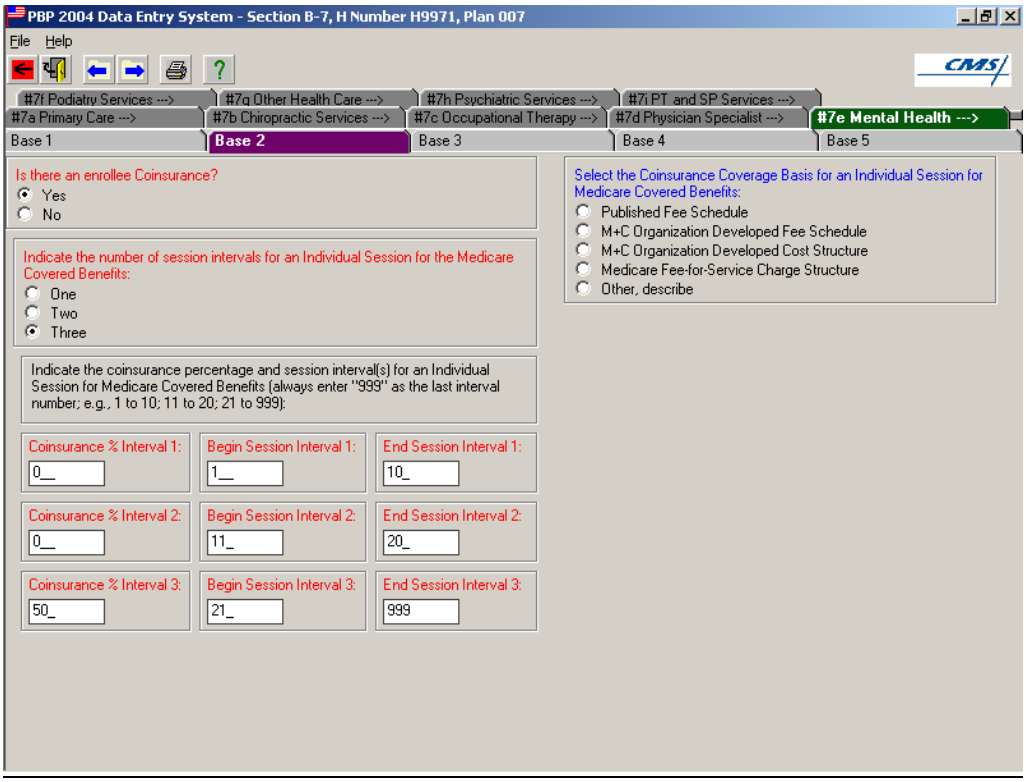
Cost sharing allows plans to enter self-designated intervals for costs per visit. Below are the instructions for entering data if a plan has cost sharing on a per visit basis.

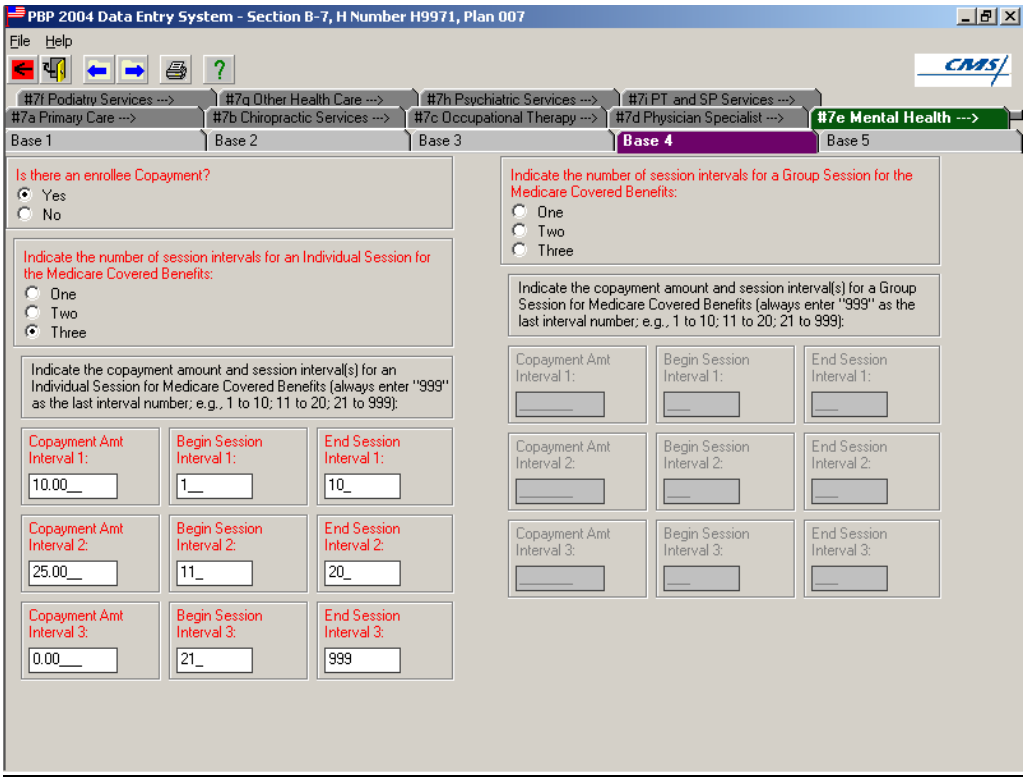
Individual/Group Visit Cost Shares: If a plan has a per visit cost structure for individual and/or group visits, the plan should explicitly price these visits. Since the visits are Medicare-covered, the plan should enter a start visit equal to '1' in the first interval, and an end visit equal to '999' in the last interval. Note that the end visit can be entered in the first, second, or third interval, depending upon the plan's cost structure.

Example: If an MCO charges $10 per visit for the first 10 visits, then $25 per visit for all visits beyond 10, the MCO should declare two intervals and enter the copayment as $10 for Visits 1 through 10 and $25 for Visits 11 through 999.



Example: If an MCO charges $10 per visit for the first 10 visits, then $25 per visits 11-20, then 50% coinsurance for all visits beyond 20, the MCO should declare three intervals for both copayment and coinsurance. The copayment intervals would be $10 for Visits 1 through 10, $25 for Visits 11 through 20, and $0 for Visits 21 through 999. The coinsurance intervals would be 0% for Visits 1 through 10, 0% for Visits 11 through 20, and 50% for Visits 21 through 999. This structure will ensure proper sentences print out in the SB.





If the cost sharing for both individual and group visits are the same, ensure that the cost sharing structure is entered exactly the same for both the individual and group visits. By doing so, one SB sentence will be produced for both types of visits, thereby eliminating unnecessary duplication.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-7f: Podiatry Services

SB 10: Podiatry Services

This category collects information on Medicare-covered and non-Medicare-covered podiatry services.

Medicare covered podiatry services only include medically necessary and reasonable foot care. Any other podiatry services that are offered, such as routine care, would be classified as either Additional, Mandatory Supplemental, or Optional Supplemental benefits.

In the SB, Medically Necessary Foot Care and Podiatry Services (Routine care) were merged into one category, "Podiatry Services". The SB sentences will continue to distinguish between the Medically Necessary Foot Care and Routine Care.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-7g: Other Health Care Professional Services

This category collects information on Medicare-covered services provided by other health care professionals.

PBP B-7h: Psychiatric Services

SB 11: Outpatient Mental Health Care

This category collects information on Medicare-covered psychiatric services.

See Section "PBP B-7e: Mental Health Specialist Services, SB 11: Outpatient Mental Health Care" above for more detailed information.

PBP B-7i: Physical Therapy and Speech-Language Pathology Services

SB 17: Outpatient Rehabilitation Services

This category collects information on Medicare-covered physical therapy and speech language pathology services.

NEW FOR 2004:

See Section B above for more detailed information regarding the facility cost sharing question.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

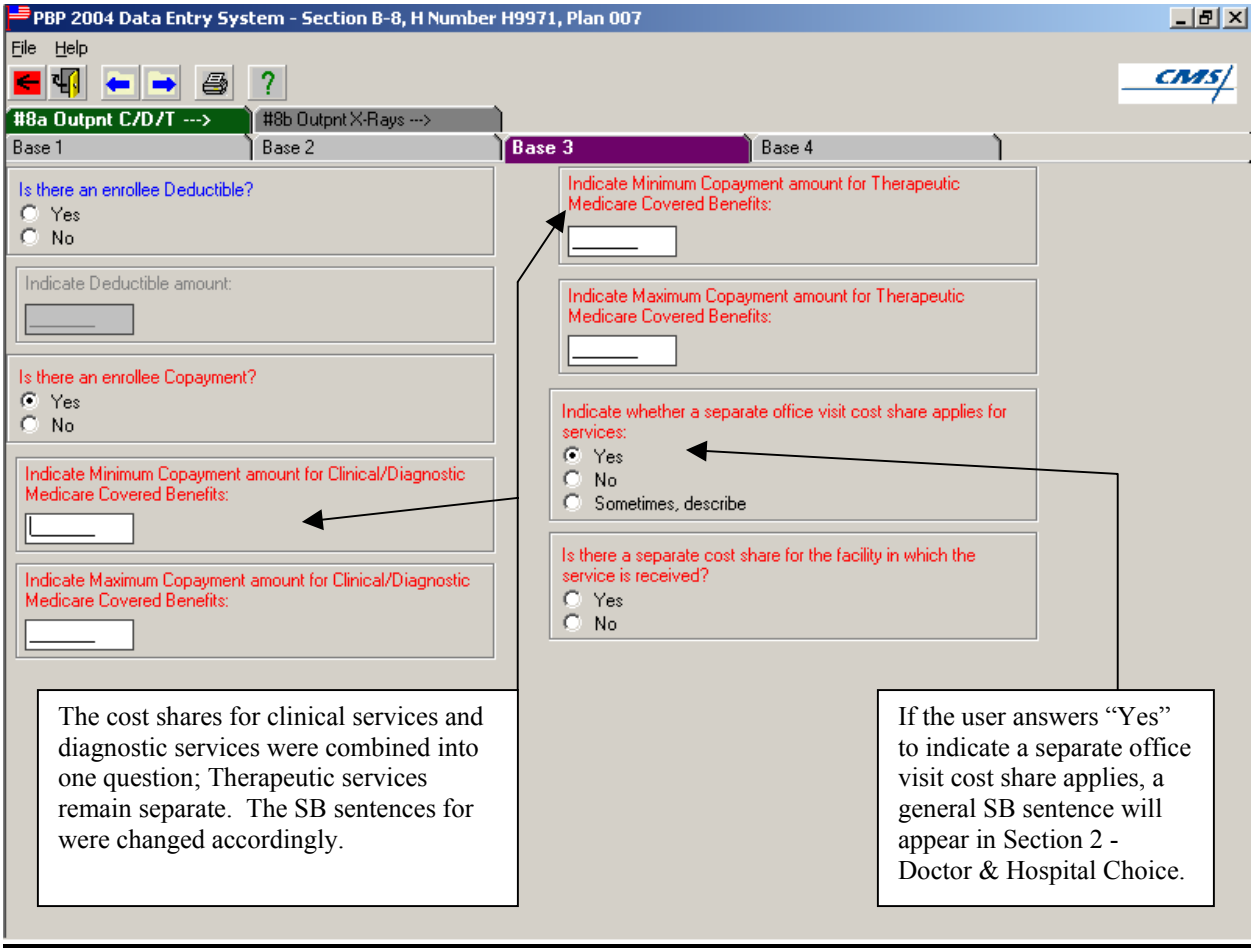
PBP B-8a: Outpatient Clinical/Diagnostic/Therapeutic Radiological Lab Services

SB 21: Diagnostic Tests, X-rays, and Lab Services

This category collects information on Medicare-covered lab services and radiation therapy.

NEW FOR 2004:
See Section B above for more detailed information regarding the facility cost sharing question.

NOTE:



SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-8b: Outpatient X-Rays

SB 21: Diagnostic Tests, X-rays, and Lab Services

This category collects information on Medicare-covered X-ray services.

NEW FOR 2004:
See Section B above for more detailed information regarding the facility cost sharing question.

NOTE: See "PBP B-8a: Outpatient Clinical/Diagnostic/Therapeutic Radiological Lab Services, SB 21: Diagnostic Tests, X-rays, and Lab Services" for more detailed information regarding the separate office visit cost share question and sentence.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-9a: Outpatient Hospital Services

SB 13: Outpatient Services

This category collects information on Medicare-covered outpatient hospital services.

NEW FOR 2004:
See Section B above for more detailed information regarding the facility cost sharing question.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-9b: Ambulatory Surgical Center (ASC) Services

SB 13: Outpatient Services

This category collects information on Medicare-covered ASC services.

NEW FOR 2004:
See Section B above for more detailed information regarding the facility cost sharing question.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-9c: Outpatient Substance Abuse Services

SB 12: Outpatient Substance Abuse Care

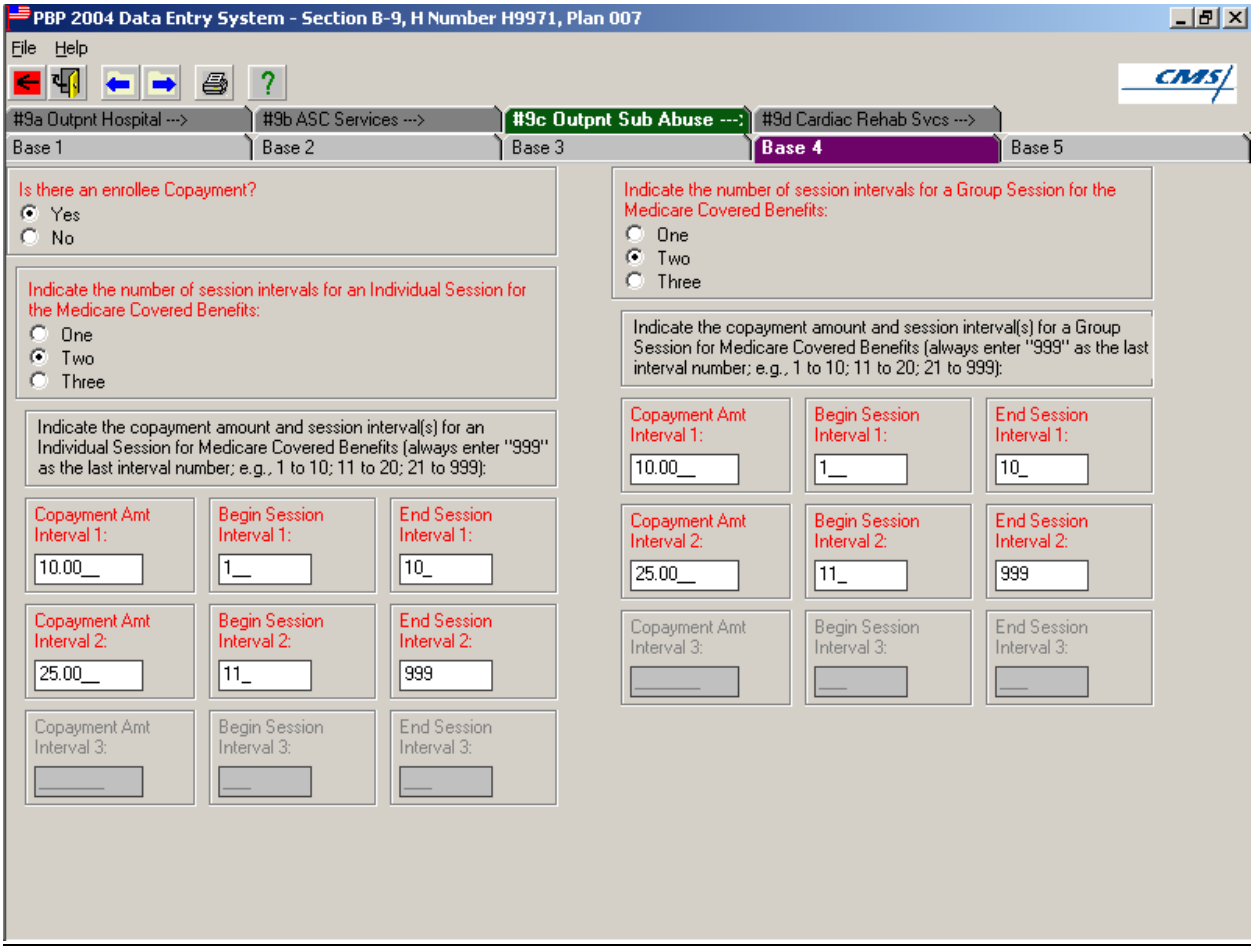
This category collects information on Medicare-covered outpatient substance abuse services.

Cost sharing allows plans to enter self-designated intervals for costs per visit. Below are the instructions for entering the cost share structure if a plan has cost sharing on a per visit basis.

Individual/Group Visit Cost Shares: If a plan has a per visit cost structure for individual and/or group visits, the plan should explicitly price these visits. Since the visits are Medicare-covered,

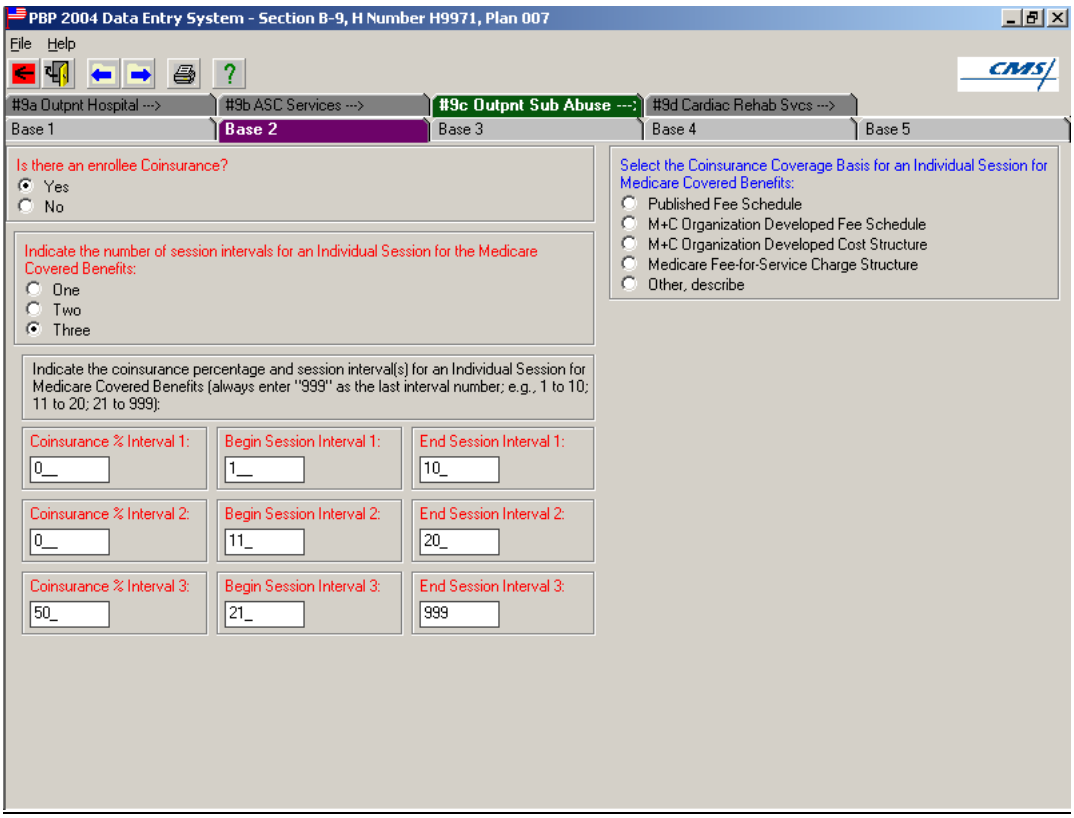
the plan should enter a start visit equal to '1' in the first interval, and an end visit equal to '999' in the last interval. Note that the end day can be entered in the first, second, or third interval, depending upon the plan's cost structure.

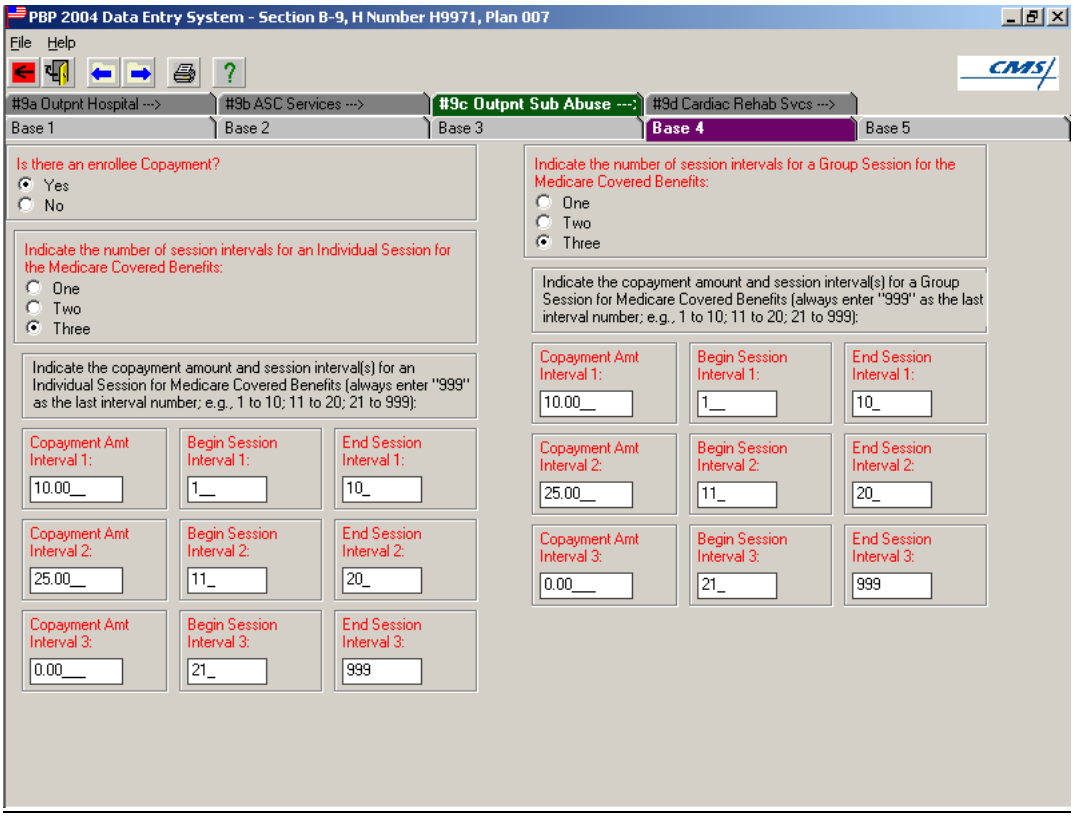
Example: If a MCO charges $10 per visit for the first 10 visits, then $25 per visit for all visits beyond 10, the MCO should enter the copayment as $10 for Visits 1 through 10 and $25 for Visits 11 through 999.



HELPFUL HINT:
If the cost sharing for both individual and group visits are the same, ensure that the cost sharing structure is entered exactly the same for both the individual and group visits. By doing so, one SB sentence will be produced for both types of visits, thereby eliminating unnecessary duplication.

Example: If an MCO charges $10 per visit for the first 10 visits, then $25 per visits 11-20, then 50% coinsurance for all visits beyond 20, the MCO should declare three intervals for both copayment and coinsurance. The copayment intervals would be $10 for Visits 1 through 10, $25 for Visits 11 through 20, and $0 for Visits 21 through 999. The coinsurance intervals would be 0% for Visits 1 through 10, 0% for Visits 11 through 20, and 50% for Visits 21 through 999. This structure will ensure proper sentences print out in the SB.


PBP 2004 Data Entry System - Section B-9, H Number H9971, Plan 007
File Help
#9a Outpnt Hospital --->
#9b ASC Services --->
#9c Outpnt Sub Abuse --->
#9d Cardiac Rehab Svcs --->
Base 1
Base 2
Base 3
Base 4
Base 5
Is there an enrollee Coinsurance?
Yes
No
Indicate the number of session intervals for an Individual Session for the Medicare Covered Benefits:
One
Two
Three
Select the Coinsurance Coverage Basis for an Individual Session for Medicare Covered Benefits:
Published Fee Schedule
M+C Organization Developed Fee Schedule
M+C Organization Developed Cost Structure
Medicare Fee-for-Service Charge Structure
Other, describe
Indicate the coinsurance percentage and session interval(s) for an Individual Session for Medicare Covered Benefits (always enter "999" as the last interval number; e.g., 1 to 10; 11 to 20; 21 to 999):
Coinsurance % Interval 1:
0__
Begin Session Interval 1:
1__
End Session Interval 1:
10_
Coinsurance % Interval 2:
0__
Begin Session Interval 2:
11_
End Session Interval 2:
20_
Coinsurance % Interval 3:
50_
Begin Session Interval 3:
21_
End Session Interval 3:
999


PBP 2004 Data Entry System - Section B-9, H Number H9971, Plan 007
File Help
#9a Outpnt Hospital --->
#9b ASC Services --->
#9c Outpnt Sub Abuse --->
#9d Cardiac Rehab Svcs --->
Base 1
Base 2
Base 3
Base 4
Base 5
Is there an enrollee Copayment?
Yes
No
Indicate the number of session intervals for an Individual Session for the Medicare Covered Benefits:
One
Two
Three
Indicate the copayment amount and session interval(s) for an Individual Session for Medicare Covered Benefits (always enter "999" as the last interval number; e.g., 1 to 10; 11 to 20; 21 to 999):
Copayment Amt Interval 1:
10.00__
Begin Session Interval 1:
1__
End Session Interval 1:
10_
Copayment Amt Interval 2:
25.00__
Begin Session Interval 2:
11_
End Session Interval 2:
20_
Copayment Amt Interval 3:
0.00___
Begin Session Interval 3:
21_
End Session Interval 3:
999
Indicate the number of session intervals for a Group Session for the Medicare Covered Benefits:
One
Two
Three
Indicate the copayment amount and session interval(s) for a Group Session for Medicare Covered Benefits (always enter "999" as the last interval number; e.g., 1 to 10; 11 to 20; 21 to 999):
Copayment Amt Interval 1:
10.00__
Begin Session Interval 1:
1__
End Session Interval 1:
10_
Copayment Amt Interval 2:
25.00__
Begin Session Interval 2:
11_
End Session Interval 2:
20_
Copayment Amt Interval 3:
0.00___
Begin Session Interval 3:
21_
End Session Interval 3:
999

NEW FOR 2004:
See Section B above for more detailed information regarding the facility cost sharing question.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-9d: Cardiac Rehabilitation Services

This category collects information on Medicare-covered cardiac rehabilitation services. There are no SB sentences associated with this category.

PBP B-10a: Ambulance Services

SB 14: Ambulance Services

This category collects information on Medicare-covered ambulance services.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-10b: Transportation Services

SB 34: Transportation

This category collects information on non-Medicare-covered transportation services. If transportation services are not offered, the category will not appear on the SB.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-11a: DME

SB 18: Durable Medical Equipment

This category collects information on Medicare-covered durable medical equipment.

Benefits information contained in the DME Services category includes all DME not related to Diabetes Monitoring Supplies.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-11b: Prosthetics and Medical Supplies

SB 19: Prosthetic Devices

This category collects information on Medicare-covered prosthetics, orthotics, and medical and surgical supplies.

In the PBP 2003, a cost share specifically for Medical Supplies was added. Data entered in the cost sharing fields of category 11b-Prosthetics and Medical Supplies should only include data for Prosthetic Devices. There is no corresponding sentence for Medical Supplies in the SB.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-11c: Diabetes Monitoring Supplies

SB 20: Diabetes Self-Monitoring Training and Supplies

This category collects information on Medicare-covered supplies for diabetes monitoring.

This category distinguishes between Diabetes Monitoring Supplies and other DME, since cost sharing often differs between these two categories. Benefit information for Diabetes Training should continue to be entered in category 14i-Diabetes Monitoring. SB sentences will distinguish between Diabetes Monitoring Training and Diabetes Monitoring Supplies.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-12: Renal Dialysis

This category collects information on Medicare-covered renal dialysis services. There are no SB sentences associated with this category.

PBP B-13a: Outpatient Blood

This category collects information on Medicare-covered blood benefits. There are no SB sentences associated with this category.

PBP B-13b: Acupuncture

SB 35: Acupuncture

This category collects information on non-Medicare-covered acupuncture benefits. If acupuncture services are not offered, the category will not appear on the SB.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-13c: Other1

The category, "Other1" should be used to describe benefits that are not provided for in other areas of the PBP, such as a massage benefit. This category should not be used to provide information on benefits that are listed in other areas such as the Hepatitis B vaccine. In addition, optional supplemental benefits and "step-ups" (see section on policy clarifications and changes for step-ups) should not be described in this category. There are no SB sentences associated with this category.

PBP B-13d: Other2

The category, "Other2" should be used to describe benefits that are not provided for in other areas of the PBP, such as a massage benefit. This category should not be used to provide information on benefits that are listed in other areas such as the Hepatitis B vaccine. In addition, optional supplemental benefits and "step-ups" (see section on policy clarifications and changes for step-ups) should not be described in this category. There are no SB sentences associated with this category.

PBP B-13e: Other3

The category, "Other3" should be used to describe benefits that are not provided for in other areas of the PBP, such as a massage benefit. This category should not be used to provide information on benefits that are listed in other areas such as the Hepatitis B vaccine. In addition, optional supplemental benefits and "step-ups" (see section on policy clarifications and changes for step-ups) should not be described in this category. There are no SB sentences associated with this category.

PBP B-14a: Health Education/Wellness

SB 33: Health/Wellness Education

This category collects information on non-Medicare-covered health education and wellness benefits. If no Health Education/Wellness services are offered, the category will not appear on the SB.

NEW FOR 2004:

If the plan indicates there is any cost sharing for additional or mandatory supplemental benefits, then a new SB sentence is generated: "Copayments may apply. Contact plan for details."

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

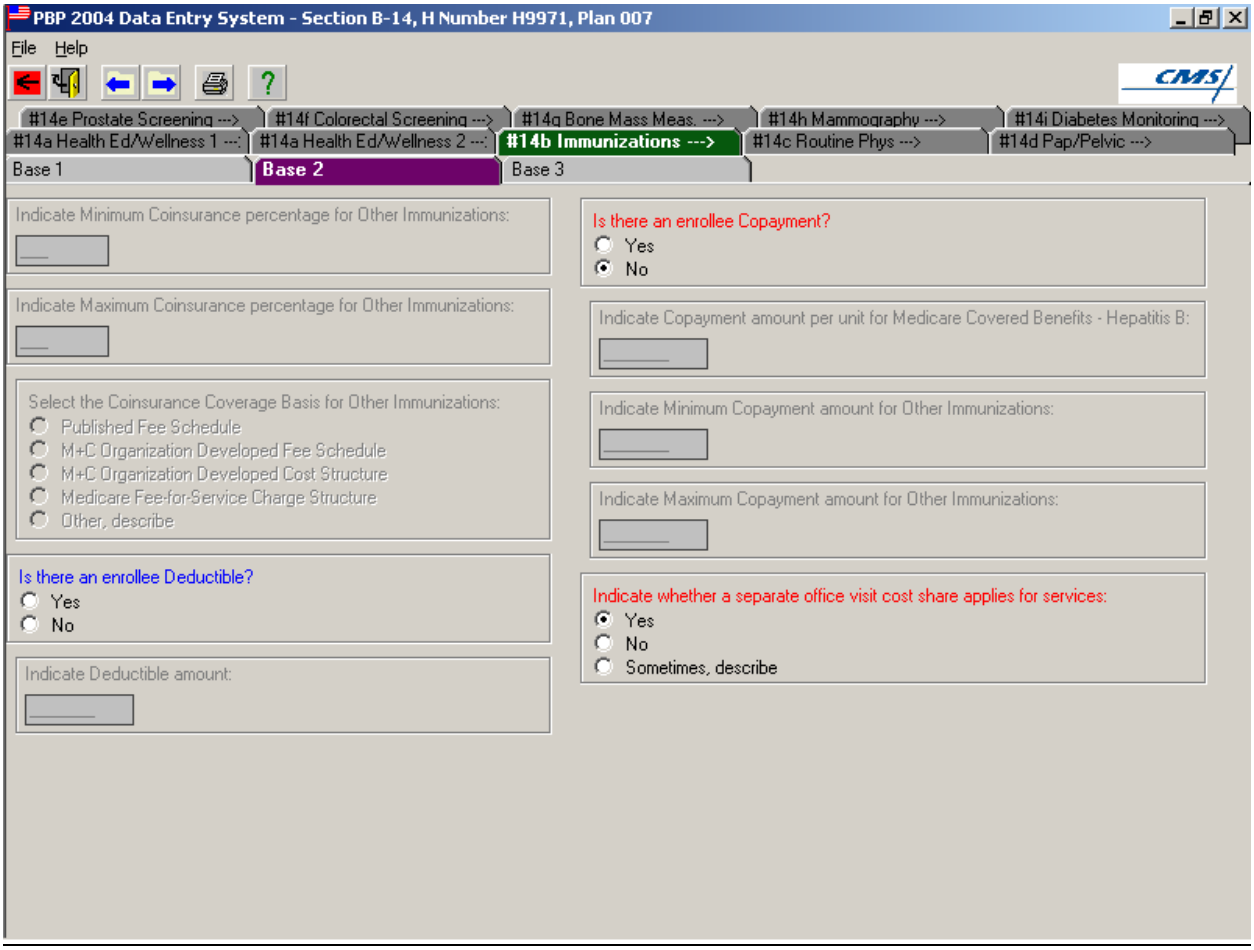
PBP B-14b: Immunizations

SB 24: Immunizations

This category collects information on Medicare-covered and non-Medicare-covered immunization benefits. The Immunization category on the SB includes some automatically generated sentences (see the PBP-SB 2004 Crosswalk).

HELPFUL HINT:

If there is no cost sharing for immunizations but a doctor office copayment does or may apply, the coinsurance/copayment questions for immunizations should be marked "No" while the question, "Indicate whether a separate office visit cost share applies for services:" should be marked either "Yes" or "Sometimes, describe". Multiple copay sentences will not be generated in the SB provided the cost sharing for the immunization is marked "No."



NEW FOR 2004:
A new sentence has been added to the SB that is automatically generated: "You may only need the Pneumococcal vaccine once in your lifetime. Please contact your doctor for further details."

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-14c: Routine Physical Exam

SB 32: Routine Physical Exams

This category collects information on non-Medicare-covered routine physicals.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-14d: Pap and Pelvic Exams

SB 26: Pap Smears and Pelvic Exams

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category. The enhanced benefits in this category reflect preventive services offered by the plan in addition to those covered by Medicare.

HELPFUL HINT:
See Section "PBP B-14b: Immunizations, SB 24: Immunizations" above for more detailed information for when a doctor's office copay may apply.

NEW FOR 2004:
See Section B above for more detailed information regarding the facility cost sharing question.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-14e: Prostate Cancer Screening

SB 27: Prostate Cancer Screening Exams

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category. The enhanced benefits in this category reflect preventive services offered by the plan in addition to those covered by Medicare.

HELPFUL HINT:
See Section "PBP B-14b: Immunizations, SB 24: Immunizations" above for more detailed information for when a doctor's office copay may apply.

NEW FOR 2004:
See Section B above for more detailed information regarding the facility cost sharing question.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-14f: Colorectal Cancer Screening

SB 23: Colorectal Screening Exams

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category.

The enhanced benefits in this category reflect preventive services offered by the plan in addition to those covered by Medicare.

HELPFUL HINT:
See Section "PBP B-14b: Immunizations, SB 24: Immunizations" above for more detailed information for when a doctor's office copay may apply.

NEW FOR 2004:
See Section B above for more detailed information regarding the facility cost sharing question.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-14g: Bone Mass Measurement

SB 22: Bone Mass Measurement

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category. The enhanced benefits in this category reflect preventive services offered by the plan in addition to those covered by Medicare.

HELPFUL HINT:
See Section "PBP B-14b: Immunizations, SB 24: Immunizations" above for more detailed information for when a doctor's office copay may apply.

NEW FOR 2004:
See Section B above for more detailed information regarding the facility cost sharing question.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-14h: Mammography Screening

SB 25: Mammograms

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category. The enhanced benefits in this category reflect preventive services offered by the plan in addition to those covered by Medicare.

HELPFUL HINT:
See Section "PBP B-14b: Immunizations, SB 24: Immunizations" above for more detailed information for when a doctor's office copay may apply.

NEW FOR 2004:
See Section B above for more detailed information regarding the facility cost sharing question.

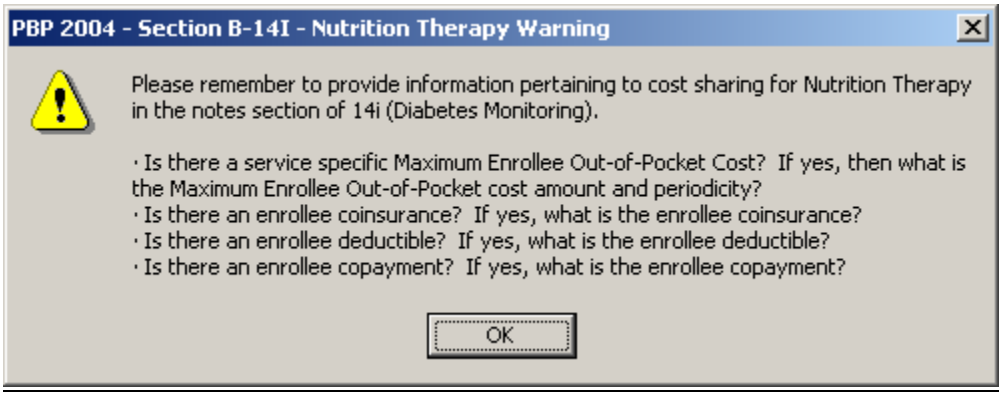
SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-14i: Diabetes Monitoring

SB 20: Diabetes Self-Monitoring Training and Supplies

This category collects information specifically for diabetes monitoring training. Diabetes supplies should be entered in category B-11c, Diabetes Monitoring Supplies.

HELPFUL HINT:
Beginning with the PBP 2003, the plan is required to provide benefit information for Nutrition Therapy in the Notes for this category. A reminder warning will display upon entry into Section B-14, shown below.



SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

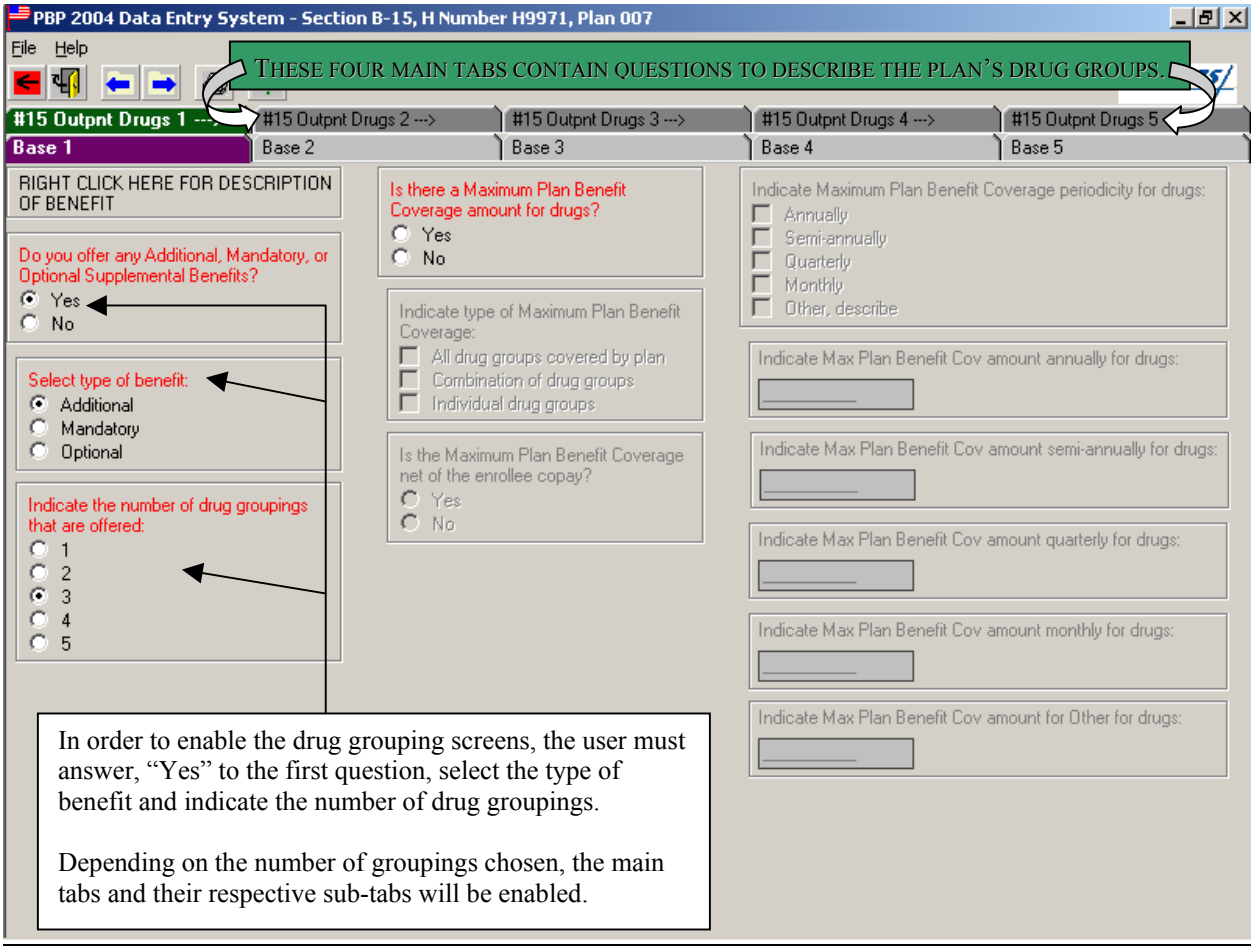
PBP B-15: Outpatient Prescription Drugs

SB 28: Outpatient Prescription Drugs

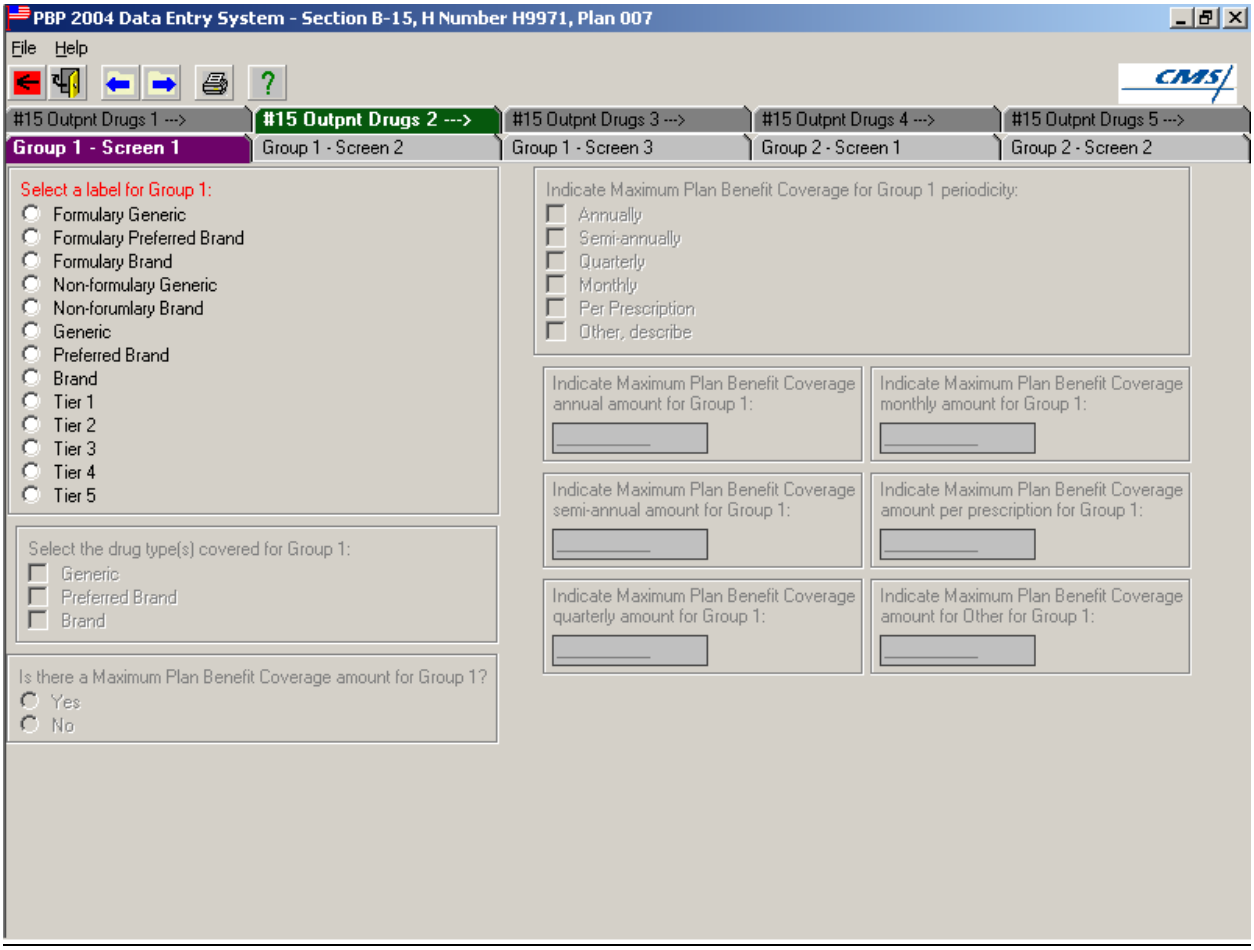
This category collects information on Medicare-covered and non-Medicare covered prescription drugs benefits offered by the plan.

NEW FOR 2004:
The PBP drug screens have been redesigned to provide more flexibility for describing a plan's drug benefit. A plan may now describe its drug benefit in terms of 'tiers', rather than having to specifically refer to Formulary/Non-formulary and Generic/Brand/Preferred Brand drugs, as in previous years. However, these drug types are also available as drug groups.

Tab 1: The set of five Base screens contains benefit level questions regarding the type of drug benefit offered by the plan (Additional, Mandatory or Optional Supplemental, or Medicare covered only), maximum plan drug benefit coverage, maximum enrollee out of pocket costs, deductibles, cost shares for Medicare covered drugs, and authorization.

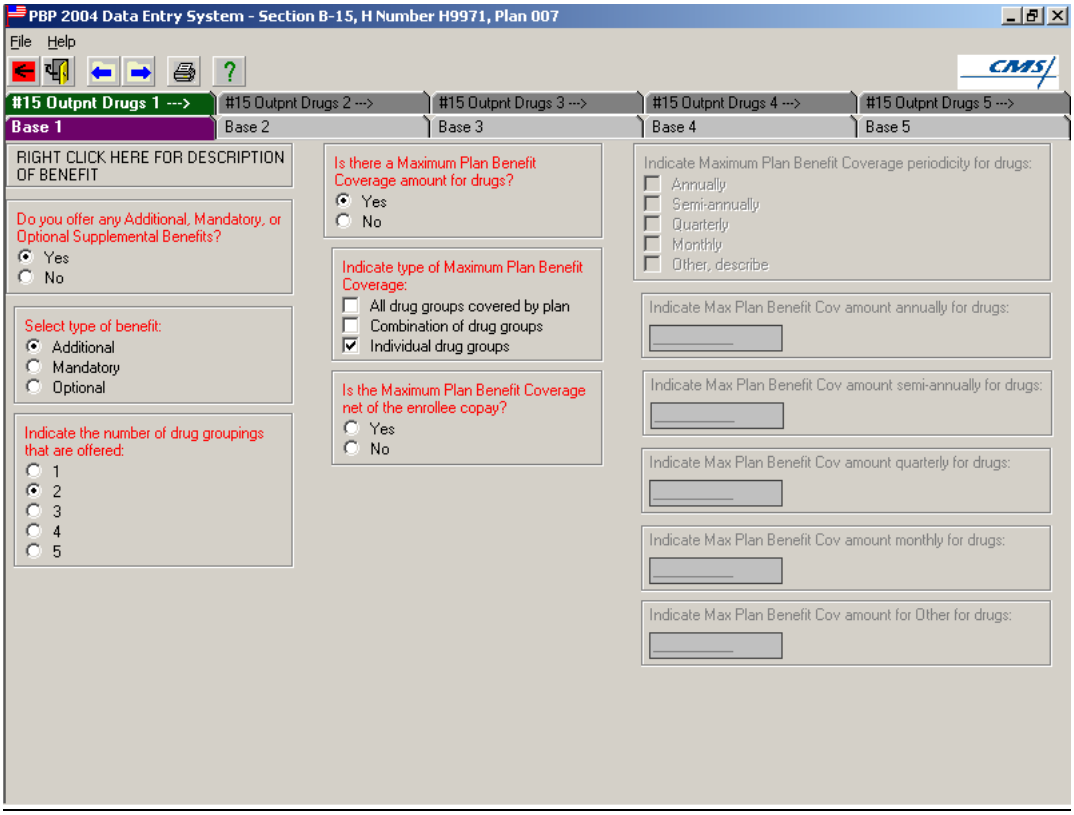


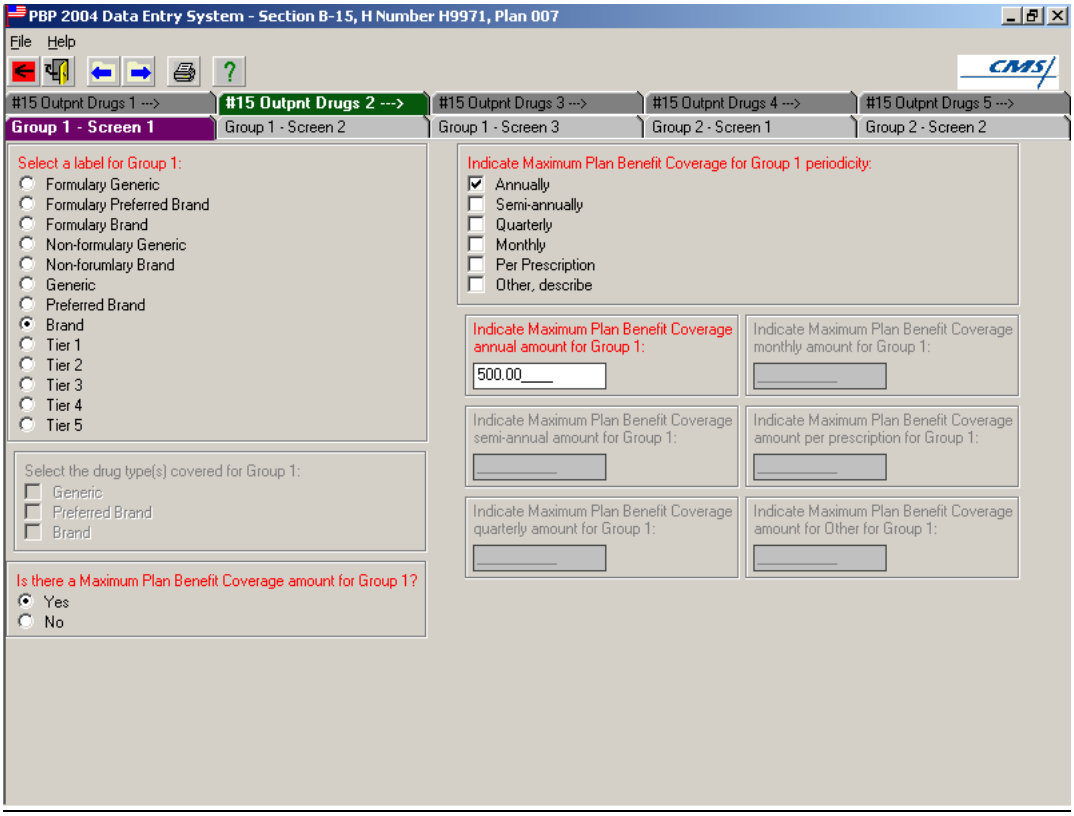
Drug Groups: There is a set of screens for each of five potential drug groups that the plan may designate to describe its drug benefit. For each drug group, the plan selects a label from a picklist that consists of: Tiers 1-5, Generic, Brand, Formulary-Generic, Formulary-Brand, Formulary-Preferred Brand, Non-formulary Generic, and Non-formulary Brand. No selection may be used more than once. If the group is designated as a tier, then the plan must indicate what drug types (Generic, Brand, Preferred Brand) are included in that tier. The plan then indicates individual coverage limits for that drug group, locations where those drugs can be acquired, cost shares, and the time limits associated with those costs.

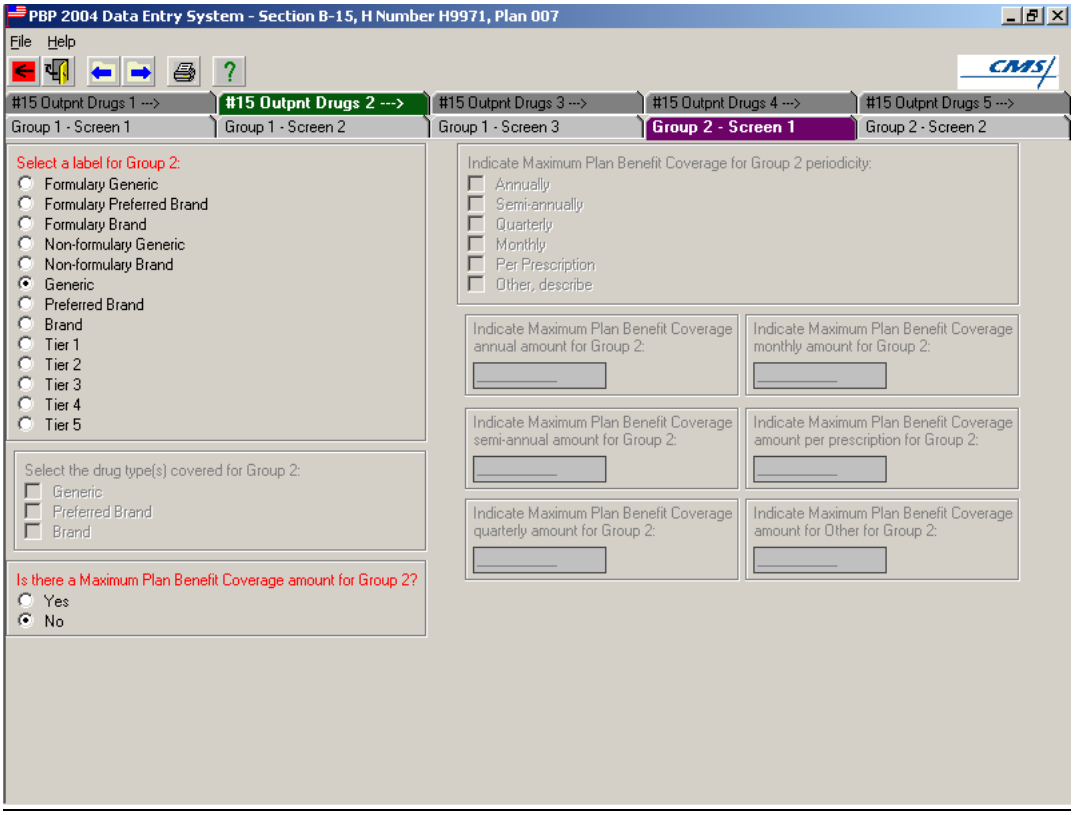


Drug Benefit Coverage Limits: A separate set of questions enables a plan to describe one or more limits on the drug benefit. If the plan indicates that it has a maximum plan benefit coverage, then the plan must designate if there is an overall limit, a limit on a combination of drug groups, and/or limit(s) on individual drug groups.

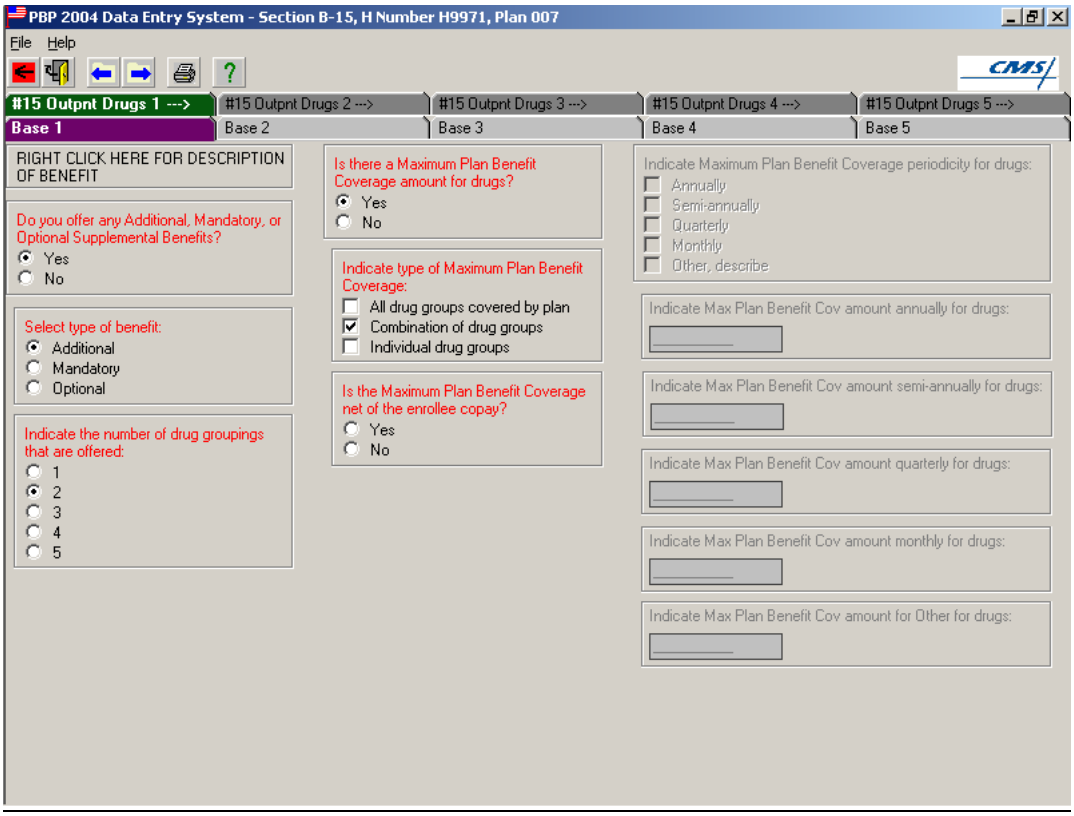
Example 1: The plan offers Brand and Generic drug groups and has a $500 annual limit on Brand drugs and unlimited Generic drugs. The plan would designate that it has a maximum plan benefit coverage, and that this includes Individual drug types. For the Brand group, the plan would indicate that there is a maximum plan benefit coverage of $500 annually, and for the Generic group, the plan would indicate that there is NO maximum plan benefit coverage.

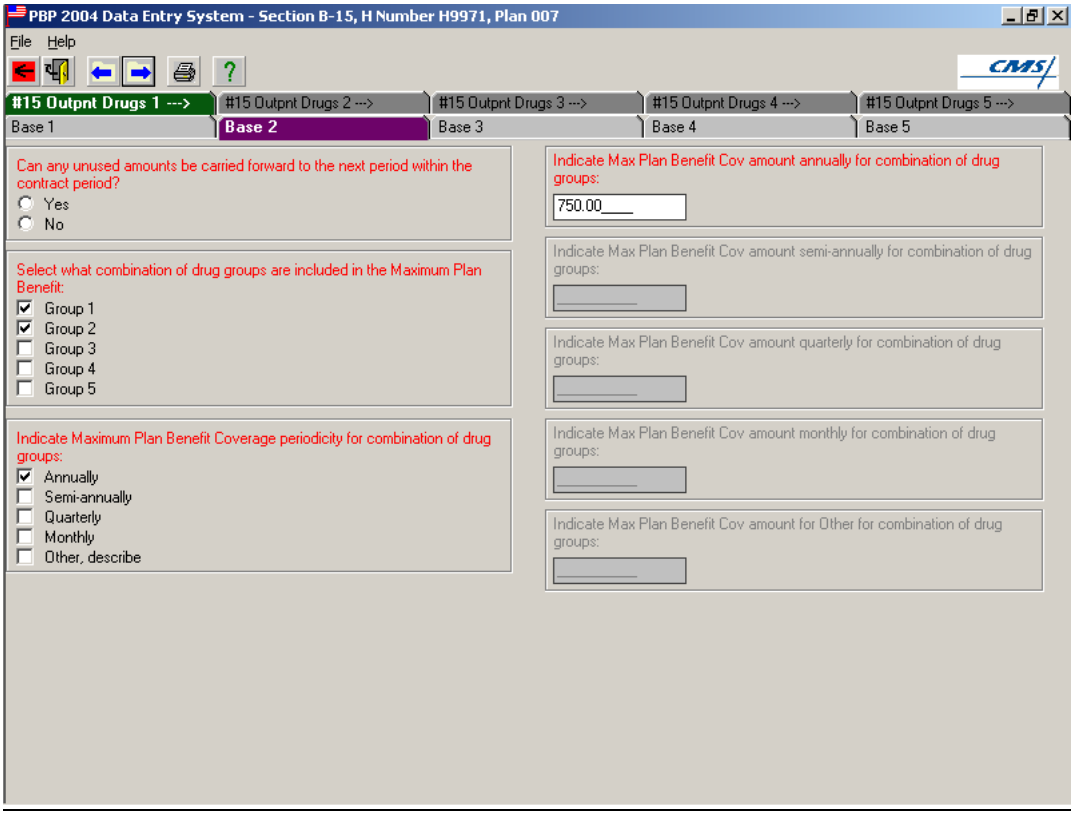

PBP 2004 Data Entry System - Section B-15, H Number H9971, Plan 007
File Help
#15 Outpnt Drugs 1 --->
#15 Outpnt Drugs 2 --->
#15 Outpnt Drugs 3 --->
#15 Outpnt Drugs 4 --->
#15 Outpnt Drugs 5 --->
Base 1
Base 2
Base 3
Base 4
Base 5
RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT
Do you offer any Additional, Mandatory, or Optional Supplemental Benefits?
Yes
No
Select type of benefit:
Additional
Mandatory
Optional
Indicate the number of drug groupings that are offered:
1
2
3
4
5
Is there a Maximum Plan Benefit Coverage amount for drugs?
Yes
No
Indicate type of Maximum Plan Benefit Coverage:
All drug groups covered by plan
Combination of drug groups
Individual drug groups
Is the Maximum Plan Benefit Coverage net of the enrollee copay?
Yes
No
Indicate Maximum Plan Benefit Coverage periodicity for drugs:
Annually
Semi-annually
Quarterly
Monthly
Other, describe
Indicate Max Plan Benefit Cov amount annually for drugs:
Indicate Max Plan Benefit Cov amount semi-annually for drugs:
Indicate Max Plan Benefit Cov amount quarterly for drugs:
Indicate Max Plan Benefit Cov amount monthly for drugs:
Indicate Max Plan Benefit Cov amount for Other for drugs:

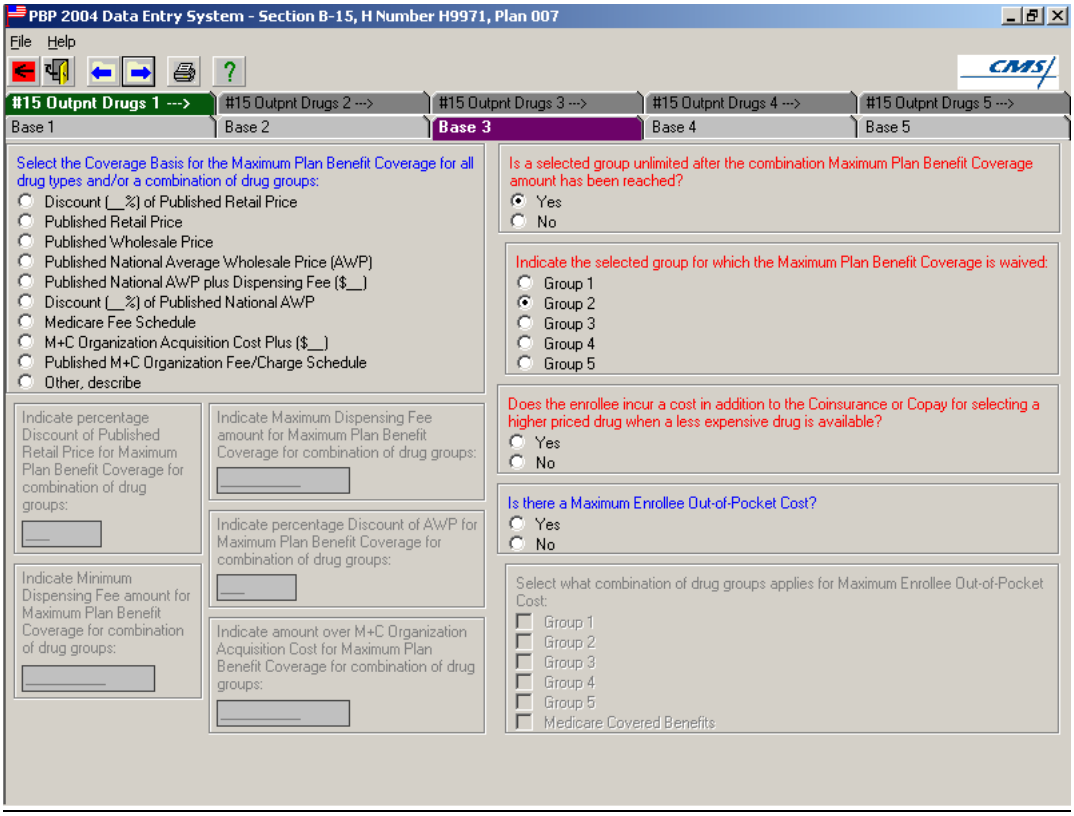

PBP 2004 Data Entry System - Section B-15, H Number H9971, Plan 007
File Help
#15 Outpnt Drugs 1 --->
#15 Outpnt Drugs 2 --->
#15 Outpnt Drugs 3 --->
#15 Outpnt Drugs 4 --->
#15 Outpnt Drugs 5 --->
Group 1 - Screen 1
Group 1 - Screen 2
Group 1 - Screen 3
Group 2 - Screen 1
Group 2 - Screen 2
Select a label for Group 1:
Formulary Generic
Formulary Preferred Brand
Formulary Brand
Non-formulary Generic
Non-forumlary Brand
Generic
Preferred Brand
Brand
Tier 1
Tier 2
Tier 3
Tier 4
Tier 5
Select the drug type(s) covered for Group 1:
Generic
Preferred Brand
Brand
Is there a Maximum Plan Benefit Coverage amount for Group 1?
Yes
No
Indicate Maximum Plan Benefit Coverage for Group 1 periodicity:
Annually
Semi-annually
Quarterly
Monthly
Per Prescription
Other, describe
Indicate Maximum Plan Benefit Coverage annual amount for Group 1:
500.00
Indicate Maximum Plan Benefit Coverage monthly amount for Group 1:
Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 1:
Indicate Maximum Plan Benefit Coverage amount per prescription for Group 1:
Indicate Maximum Plan Benefit Coverage quarterly amount for Group 1:
Indicate Maximum Plan Benefit Coverage amount for Other for Group 1:

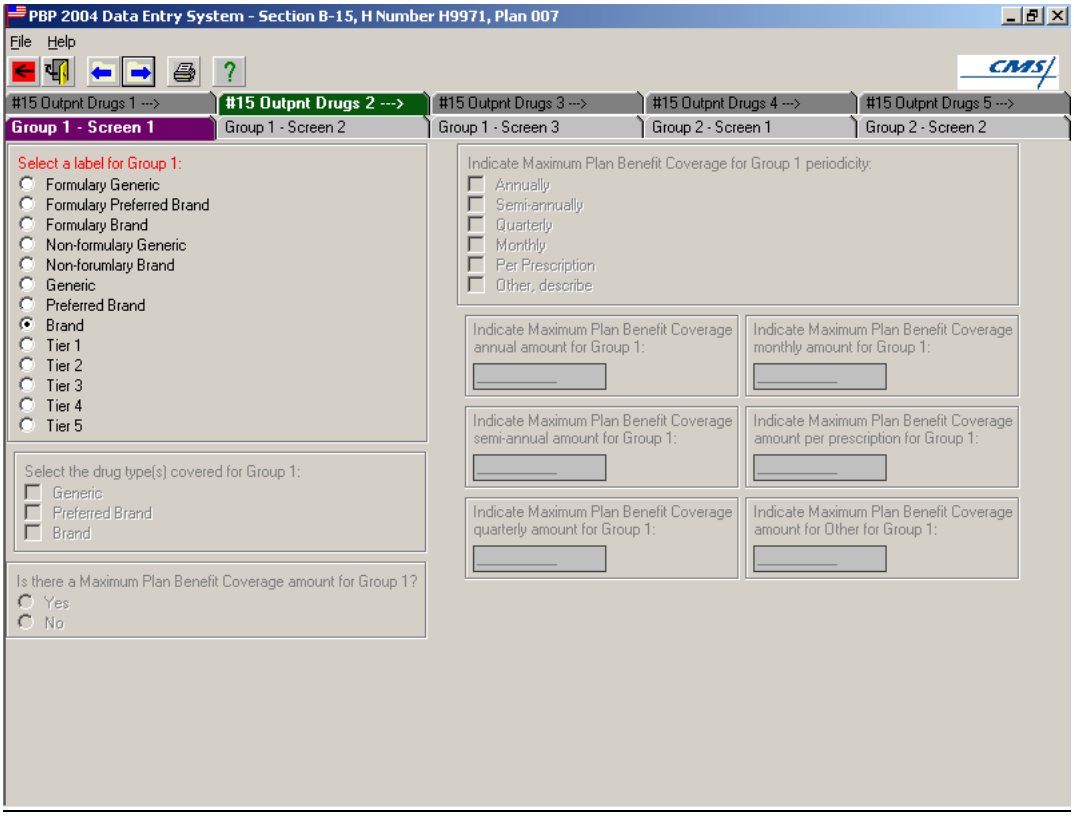

PBP 2004 Data Entry System - Section B-15, H Number H9971, Plan 007
File
Help
CMS
#15 Outpnt Drugs 1 --->
#15 Outpnt Drugs 2 --->
#15 Outpnt Drugs 3 --->
#15 Outpnt Drugs 4 --->
#15 Outpnt Drugs 5 --->
Group 1 - Screen 1
Group 1 - Screen 2
Group 1 - Screen 3
Group 2 - Screen 1
Group 2 - Screen 2
Select a label for Group 2:
Formulary Generic
Formulary Preferred Brand
Formulary Brand
Non-formulary Generic
Non-formulary Brand
Generic
Preferred Brand
Brand
Tier 1
Tier 2
Tier 3
Tier 4
Tier 5
Select the drug type(s) covered for Group 2:
Generic
Preferred Brand
Brand
Is there a Maximum Plan Benefit Coverage amount for Group 2?
Yes
No
Indicate Maximum Plan Benefit Coverage for Group 2 periodicity:
Annually
Semi-annually
Quarterly
Monthly
Per Prescription
Other, describe
Indicate Maximum Plan Benefit Coverage annual amount for Group 2:
Indicate Maximum Plan Benefit Coverage monthly amount for Group 2:
Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 2:
Indicate Maximum Plan Benefit Coverage amount per prescription for Group 2:
Indicate Maximum Plan Benefit Coverage quarterly amount for Group 2:
Indicate Maximum Plan Benefit Coverage amount for Other for Group 2:

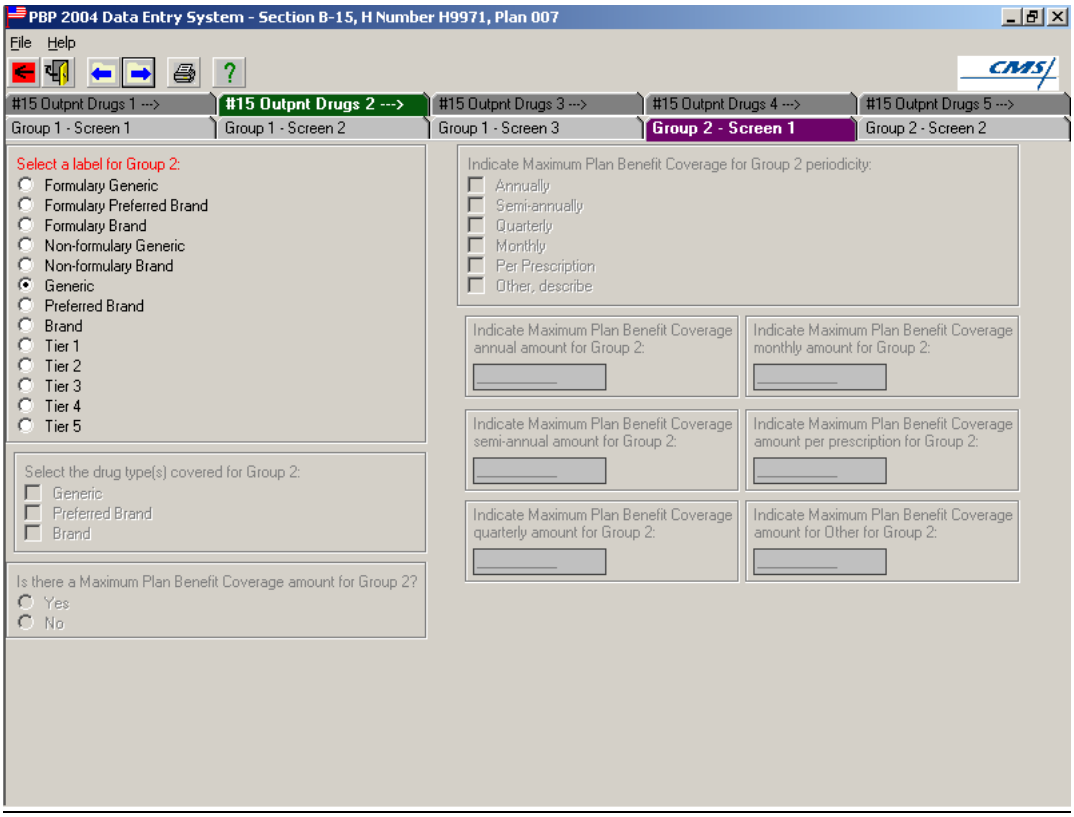
Example 2: The plan offers two drug groups - Brand and Generic, and has a $750 annual limit on the combination of drugs, but unlimited Generic after the limit is reached. The plan would designate that it has a maximum plan benefit coverage, and that this includes Combination of drug groups. The plan would select Group 1 and Group 2 as the combination of drug groups included in the maximum plan benefit coverage, and enter an overall limit of $750 annually. Following this, the plan would indicate that there is a selected group that is unlimited after the combination max limit has been reached, and select the group (1 or 2) that will be labeled as Generic.



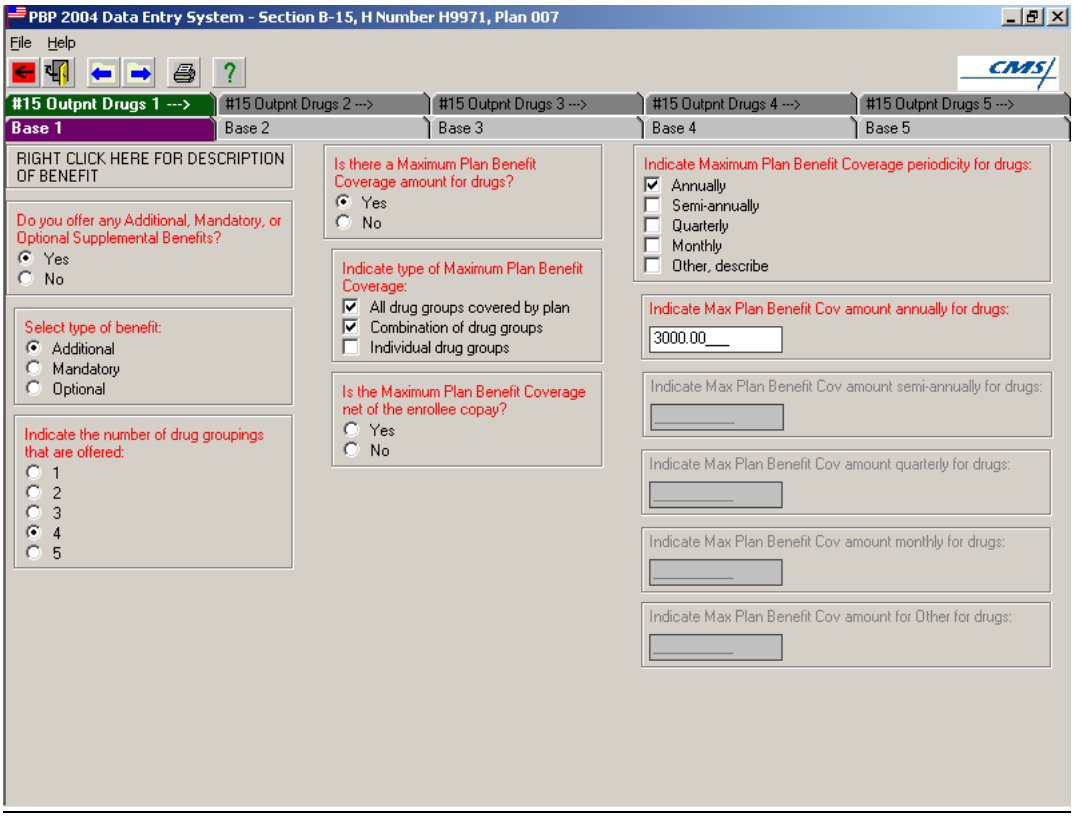

PBP 2004 Data Entry System - Section B-15, H Number H9971, Plan 007
File Help
#15 Outpnt Drugs 1 --->
#15 Outpnt Drugs 2 --->
#15 Outpnt Drugs 3 --->
#15 Outpnt Drugs 4 --->
#15 Outpnt Drugs 5 --->
Base 1
Base 2
Base 3
Base 4
Base 5
Can any unused amounts be carried forward to the next period within the contract period?
Yes
No
Select what combination of drug groups are included in the Maximum Plan Benefit:
Group 1
Group 2
Group 3
Group 4
Group 5
Indicate Maximum Plan Benefit Coverage periodicity for combination of drug groups:
Annually
Semi-annually
Quarterly
Monthly
Other, describe
Indicate Max Plan Benefit Cov amount annually for combination of drug groups:
750.00
Indicate Max Plan Benefit Cov amount semi-annually for combination of drug groups:
Indicate Max Plan Benefit Cov amount quarterly for combination of drug groups:
Indicate Max Plan Benefit Cov amount monthly for combination of drug groups:
Indicate Max Plan Benefit Cov amount for Other for combination of drug groups:

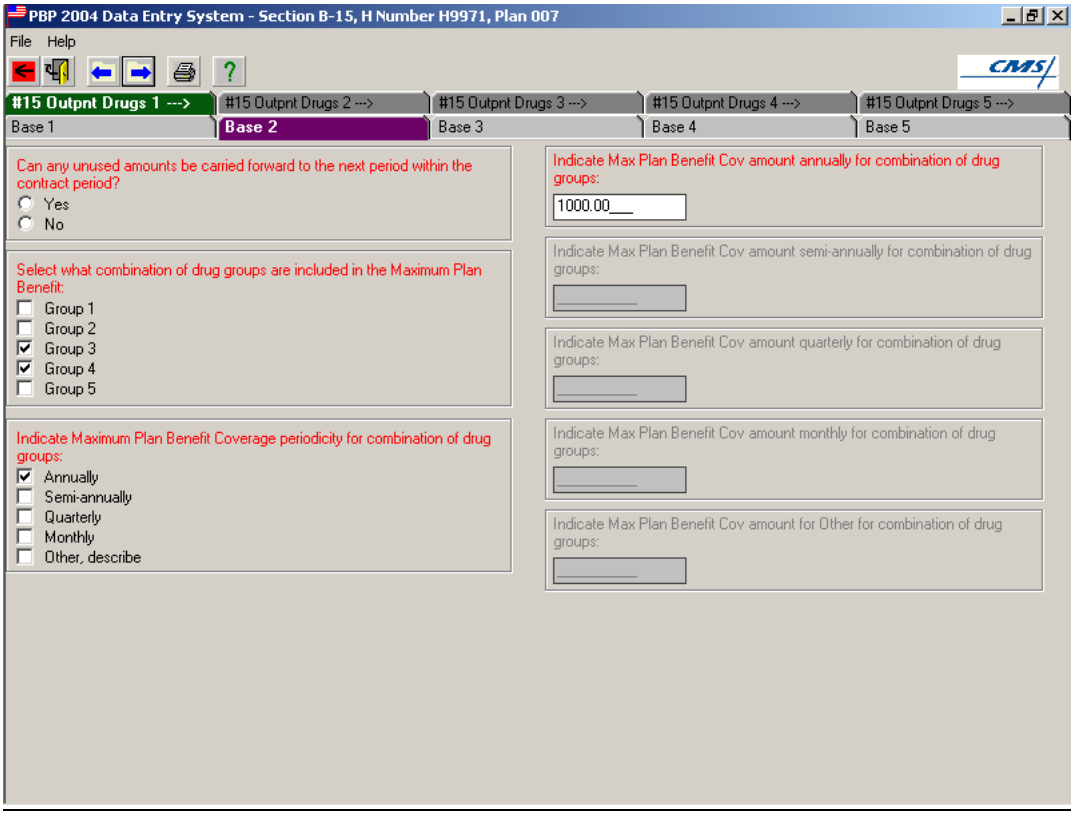

PBP 2004 Data Entry System - Section B-15, H Number H9971, Plan 007
File Help
#15 Outpnt Drugs 1 --->
#15 Outpnt Drugs 2 --->
#15 Outpnt Drugs 3 --->
#15 Outpnt Drugs 4 --->
#15 Outpnt Drugs 5 --->
Base 1
Base 2
Base 3
Base 4
Base 5
Select the Coverage Basis for the Maximum Plan Benefit Coverage for all drug types and/or a combination of drug groups:
Discount (__%) of Published Retail Price
Published Retail Price
Published Wholesale Price
Published National Average Wholesale Price (AWP)
Published National AWP plus Dispensing Fee ($__)
Discount (__%) of Published National AWP
Medicare Fee Schedule
M+C Organization Acquisition Cost Plus ($__)
Published M+C Organization Fee/Charge Schedule
Other, describe
Indicate percentage Discount of Published Retail Price for Maximum Plan Benefit Coverage for combination of drug groups:
Indicate Minimum Dispensing Fee amount for Maximum Plan Benefit Coverage for combination of drug groups:
Indicate Maximum Dispensing Fee amount for Maximum Plan Benefit Coverage for combination of drug groups:
Indicate percentage Discount of AWP for Maximum Plan Benefit Coverage for combination of drug groups:
Indicate amount over M+C Organization Acquisition Cost for Maximum Plan Benefit Coverage for combination of drug groups:
Is a selected group unlimited after the combination Maximum Plan Benefit Coverage amount has been reached?
Yes
No
Indicate the selected group for which the Maximum Plan Benefit Coverage is waived:
Group 1
Group 2
Group 3
Group 4
Group 5
Does the enrollee incur a cost in addition to the Coinsurance or Copay for selecting a higher priced drug when a less expensive drug is available?
Yes
No
Is there a Maximum Enrollee Out-of-Pocket Cost?
Yes
No
Select what combination of drug groups applies for Maximum Enrollee Out-of-Pocket Cost:
Group 1
Group 2
Group 3
Group 4
Group 5
Medicare Covered Benefits

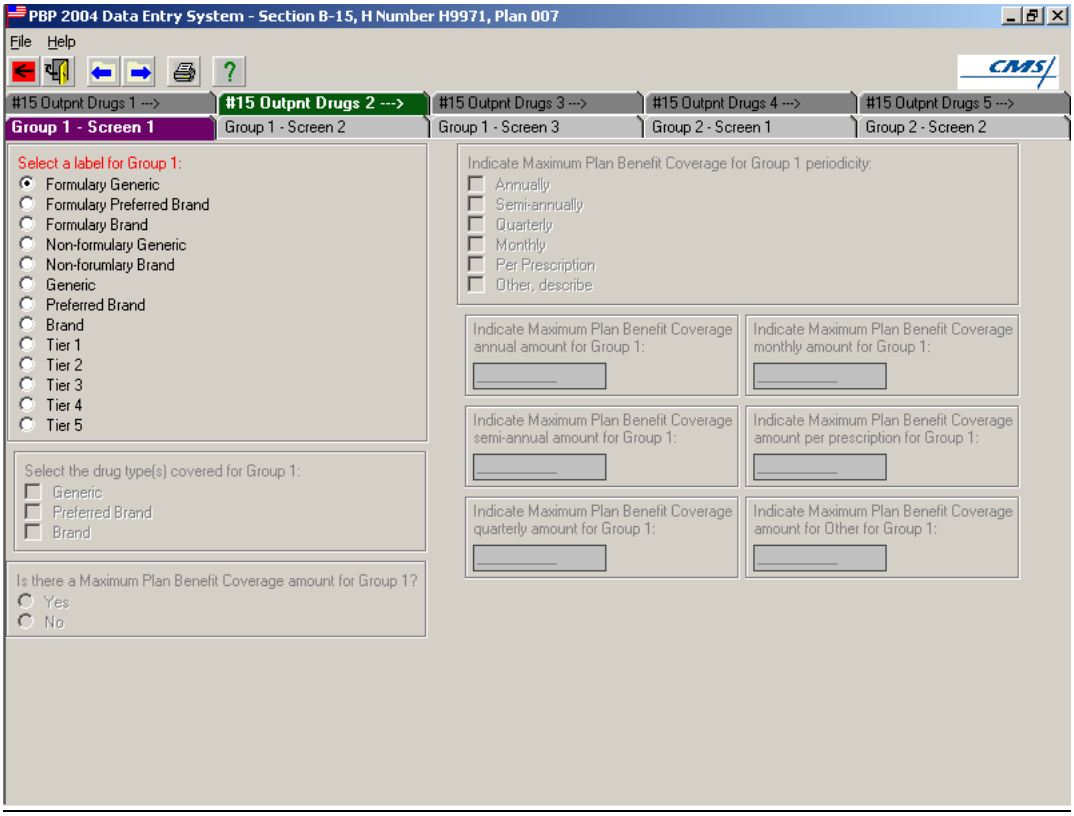

PBP 2004 Data Entry System - Section B-15, H Number H9971, Plan 007
File Help
CMS
#15 Outpnt Drugs 1 --->
#15 Outpnt Drugs 2 --->
#15 Outpnt Drugs 3 --->
#15 Outpnt Drugs 4 --->
#15 Outpnt Drugs 5 --->
Group 1 - Screen 1
Group 1 - Screen 2
Group 1 - Screen 3
Group 2 - Screen 1
Group 2 - Screen 2
Select a label for Group 1:
Formulary Generic
Formulary Preferred Brand
Formulary Brand
Non-formulary Generic
Non-forumlary Brand
Generic
Preferred Brand
Brand
Tier 1
Tier 2
Tier 3
Tier 4
Tier 5
Select the drug type(s) covered for Group 1:
Generic
Preferred Brand
Brand
Is there a Maximum Plan Benefit Coverage amount for Group 1?
Yes
No
Indicate Maximum Plan Benefit Coverage for Group 1 periodicity:
Annually
Semi-annually
Quarterly
Monthly
Per Prescription
Other, describe
Indicate Maximum Plan Benefit Coverage annual amount for Group 1:
Indicate Maximum Plan Benefit Coverage monthly amount for Group 1:
Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 1:
Indicate Maximum Plan Benefit Coverage amount per prescription for Group 1:
Indicate Maximum Plan Benefit Coverage quarterly amount for Group 1:
Indicate Maximum Plan Benefit Coverage amount for Other for Group 1:

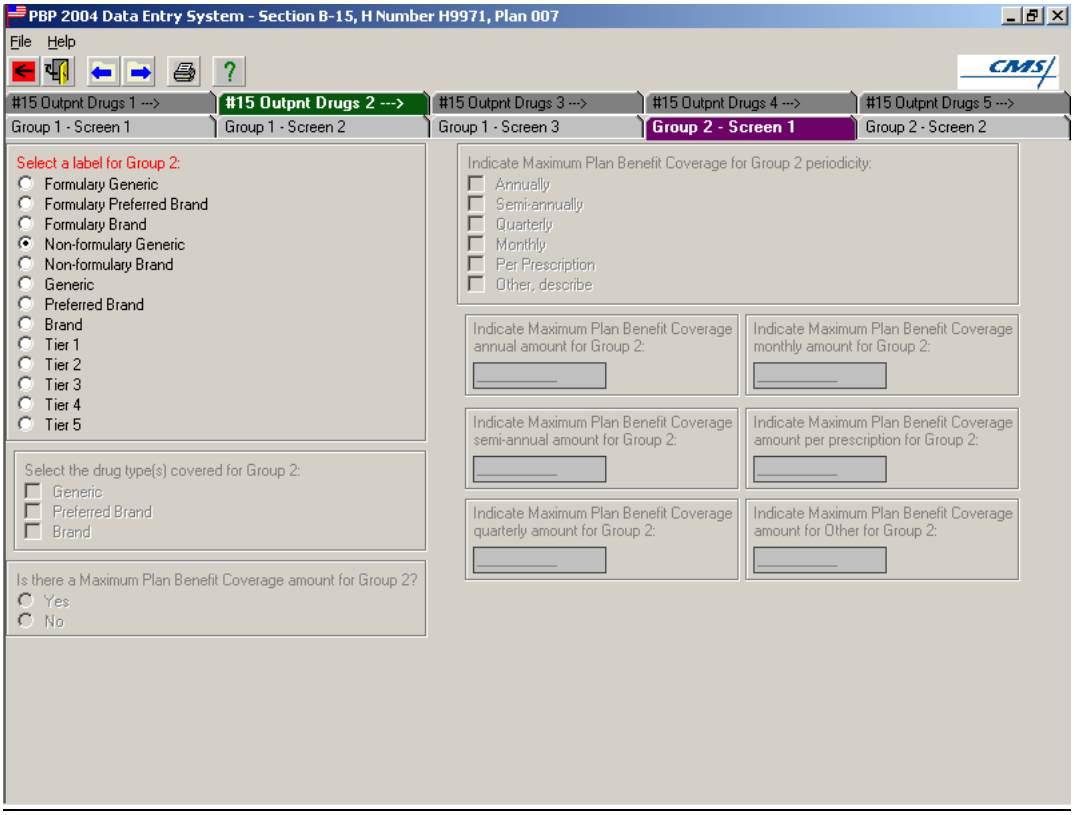

PBP 2004 Data Entry System - Section B-15, H Number H9971, Plan 007
File Help
CMS
#15 Outpnt Drugs 1 --->
#15 Outpnt Drugs 2 --->
#15 Outpnt Drugs 3 --->
#15 Outpnt Drugs 4 --->
#15 Outpnt Drugs 5 --->
Group 1 - Screen 1
Group 1 - Screen 2
Group 1 - Screen 3
Group 2 - Screen 1
Group 2 - Screen 2
Select a label for Group 2:
Formulary Generic
Formulary Preferred Brand
Formulary Brand
Non-formulary Generic
Non-formulary Brand
Generic
Preferred Brand
Brand
Tier 1
Tier 2
Tier 3
Tier 4
Tier 5
Select the drug type(s) covered for Group 2:
Generic
Preferred Brand
Brand
Is there a Maximum Plan Benefit Coverage amount for Group 2?
Yes
No
Indicate Maximum Plan Benefit Coverage for Group 2 periodicity:
Annually
Semi-annually
Quarterly
Monthly
Per Prescription
Other, describe
Indicate Maximum Plan Benefit Coverage annual amount for Group 2:
Indicate Maximum Plan Benefit Coverage monthly amount for Group 2:
Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 2:
Indicate Maximum Plan Benefit Coverage amount per prescription for Group 2:
Indicate Maximum Plan Benefit Coverage quarterly amount for Group 2:
Indicate Maximum Plan Benefit Coverage amount for Other for Group 2:

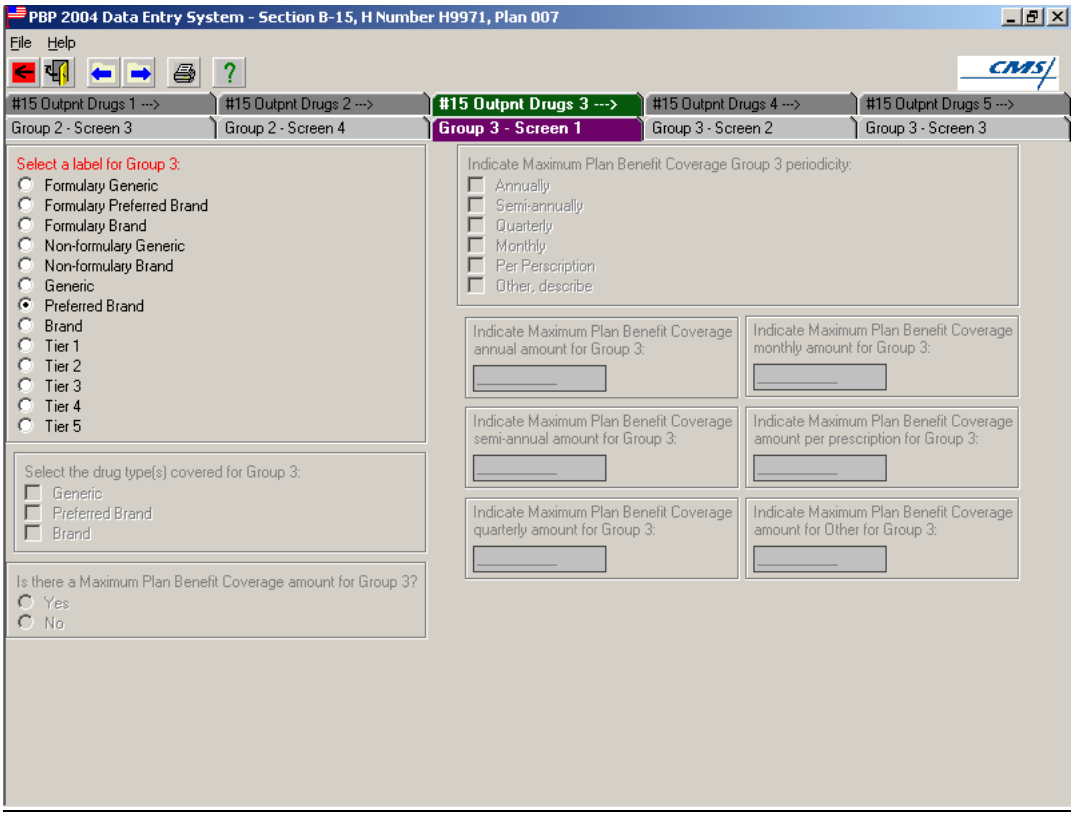
Example 3: The plan has a $3,000 annual limit on four drug groups, with a $1,000 annual limit on Groups 3 and 4 combined, and no individual limit on Groups1 and 2. In this scenario, the plan would designate that it has a maximum plan benefit coverage, and that this includes All drug groups covered by plan AND Combination of drug groups. The plan would enter the overall limit of $3,000 annually, and a combination limit of $1,000 annually that includes the Groups 3 and 4 in the combination.

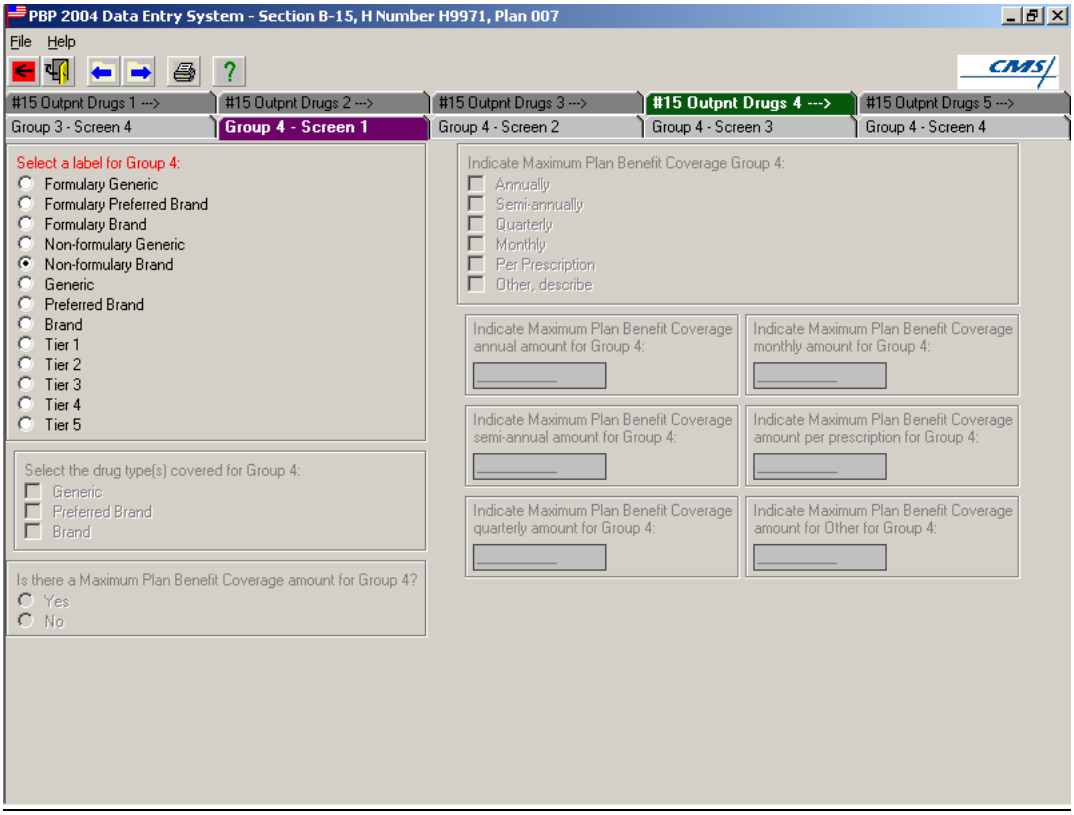



PBP 2004 Data Entry System - Section B-15, H Number H9971, Plan 007
File Help
#15 Outpnt Drugs 1 --->
#15 Outpnt Drugs 2 --->
#15 Outpnt Drugs 3 --->
#15 Outpnt Drugs 4 --->
#15 Outpnt Drugs 5 --->
Base 1
Base 2
Base 3
Base 4
Base 5
Can any unused amounts be carried forward to the next period within the contract period?
Yes
No
Select what combination of drug groups are included in the Maximum Plan Benefit:
Group 1
Group 2
Group 3
Group 4
Group 5
Indicate Maximum Plan Benefit Coverage periodicity for combination of drug groups:
Annually
Semi-annually
Quarterly
Monthly
Other, describe
Indicate Max Plan Benefit Cov amount annually for combination of drug groups:
1000.00
Indicate Max Plan Benefit Cov amount semi-annually for combination of drug groups:
Indicate Max Plan Benefit Cov amount quarterly for combination of drug groups:
Indicate Max Plan Benefit Cov amount monthly for combination of drug groups:
Indicate Max Plan Benefit Cov amount for Other for combination of drug groups:


PBP 2004 Data Entry System - Section B-15, H Number H9971, Plan 007
File Help
#15 Outpnt Drugs 1 --->
#15 Outpnt Drugs 2 --->
#15 Outpnt Drugs 3 --->
#15 Outpnt Drugs 4 --->
#15 Outpnt Drugs 5 --->
Group 1 - Screen 1
Group 1 - Screen 2
Group 1 - Screen 3
Group 2 - Screen 1
Group 2 - Screen 2
Select a label for Group 1:
Formulary Generic
Formulary Preferred Brand
Formulary Brand
Non-formulary Generic
Non-forumlary Brand
Generic
Preferred Brand
Brand
Tier 1
Tier 2
Tier 3
Tier 4
Tier 5
Select the drug type(s) covered for Group 1:
Generic
Preferred Brand
Brand
Is there a Maximum Plan Benefit Coverage amount for Group 1?
Yes
No
Indicate Maximum Plan Benefit Coverage for Group 1 periodicity:
Annually
Semi-annually
Quarterly
Monthly
Per Prescription
Other, describe
Indicate Maximum Plan Benefit Coverage annual amount for Group 1:
Indicate Maximum Plan Benefit Coverage monthly amount for Group 1:
Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 1:
Indicate Maximum Plan Benefit Coverage amount per prescription for Group 1:
Indicate Maximum Plan Benefit Coverage quarterly amount for Group 1:
Indicate Maximum Plan Benefit Coverage amount for Other for Group 1:


PBP 2004 Data Entry System - Section B-15, H Number H9971, Plan 007
File Help
#15 Outpnt Drugs 1 --->
#15 Outpnt Drugs 2 --->
#15 Outpnt Drugs 3 --->
#15 Outpnt Drugs 4 --->
#15 Outpnt Drugs 5 --->
Group 1 - Screen 1
Group 1 - Screen 2
Group 1 - Screen 3
Group 2 - Screen 1
Group 2 - Screen 2
Select a label for Group 2:
Formulary Generic
Formulary Preferred Brand
Formulary Brand
Non-formulary Generic
Non-formulary Brand
Generic
Preferred Brand
Brand
Tier 1
Tier 2
Tier 3
Tier 4
Tier 5
Select the drug type(s) covered for Group 2:
Generic
Preferred Brand
Brand
Is there a Maximum Plan Benefit Coverage amount for Group 2?
Yes
No
Indicate Maximum Plan Benefit Coverage for Group 2 periodicity:
Annually
Semi-annually
Quarterly
Monthly
Per Prescription
Other, describe
Indicate Maximum Plan Benefit Coverage annual amount for Group 2:
Indicate Maximum Plan Benefit Coverage monthly amount for Group 2:
Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 2:
Indicate Maximum Plan Benefit Coverage amount per prescription for Group 2:
Indicate Maximum Plan Benefit Coverage quarterly amount for Group 2:
Indicate Maximum Plan Benefit Coverage amount for Other for Group 2:


PBP 2004 Data Entry System - Section B-15, H Number H9971, Plan 007
File Help
#15 Outpnt Drugs 1 --->
#15 Outpnt Drugs 2 --->
#15 Outpnt Drugs 3 --->
#15 Outpnt Drugs 4 --->
#15 Outpnt Drugs 5 --->
Group 2 - Screen 3
Group 2 - Screen 4
Group 3 - Screen 1
Group 3 - Screen 2
Group 3 - Screen 3
Select a label for Group 3:
Formulary Generic
Formulary Preferred Brand
Formulary Brand
Non-formulary Generic
Non-formulary Brand
Generic
Preferred Brand
Brand
Tier 1
Tier 2
Tier 3
Tier 4
Tier 5
Select the drug type(s) covered for Group 3:
Generic
Preferred Brand
Brand
Is there a Maximum Plan Benefit Coverage amount for Group 3?
Yes
No
Indicate Maximum Plan Benefit Coverage Group 3 periodicity:
Annually
Semi-annually
Quarterly
Monthly
Per Perscription
Other, describe
Indicate Maximum Plan Benefit Coverage annual amount for Group 3:
Indicate Maximum Plan Benefit Coverage monthly amount for Group 3:
Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 3:
Indicate Maximum Plan Benefit Coverage amount per prescription for Group 3:
Indicate Maximum Plan Benefit Coverage quarterly amount for Group 3:
Indicate Maximum Plan Benefit Coverage amount for Other for Group 3:



Drug Maximum Enrollee Out-of-Pocket Costs: The plan should indicate if there is an overall drug benefit maximum enrollee out-of-pocket cost on the Base 3 screen. On this screen, the plan can also select the drug groups, including Medicare covered benefits, to which the out-of-pocket maximum applies. There are no other enrollee out-of-pocket cost questions for any of the individual drug groups.

Deductible: The plan should specify the drug benefit deductible amount on the Base 5 screen. On this screen, the plan can also select the drug groups, including Medicare covered benefits, to which the deductible applies. There are no other deductible questions for any of the individual drug groups.

Coinsurance/Copayment: The coinsurance and copayment amounts for Medicare covered drugs should be entered in the Base screens. The coinsurance and copayment amounts for each of the individual drug groups should be entered in the appropriate Group set of screens.

Authorization: One Authorization question remains in the Prescription Drug category on Base 5. Written prescriptions from a physician are not considered to be an authorization for this category.

NOTE:

- There is only one Notes field for this category and it is located on the Notes screen.
- The SB sentences for prescription drugs have been revised based on the redesigned questions and answers. Please refer to the PBP-SB Crosswalk for further details on the sentences.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

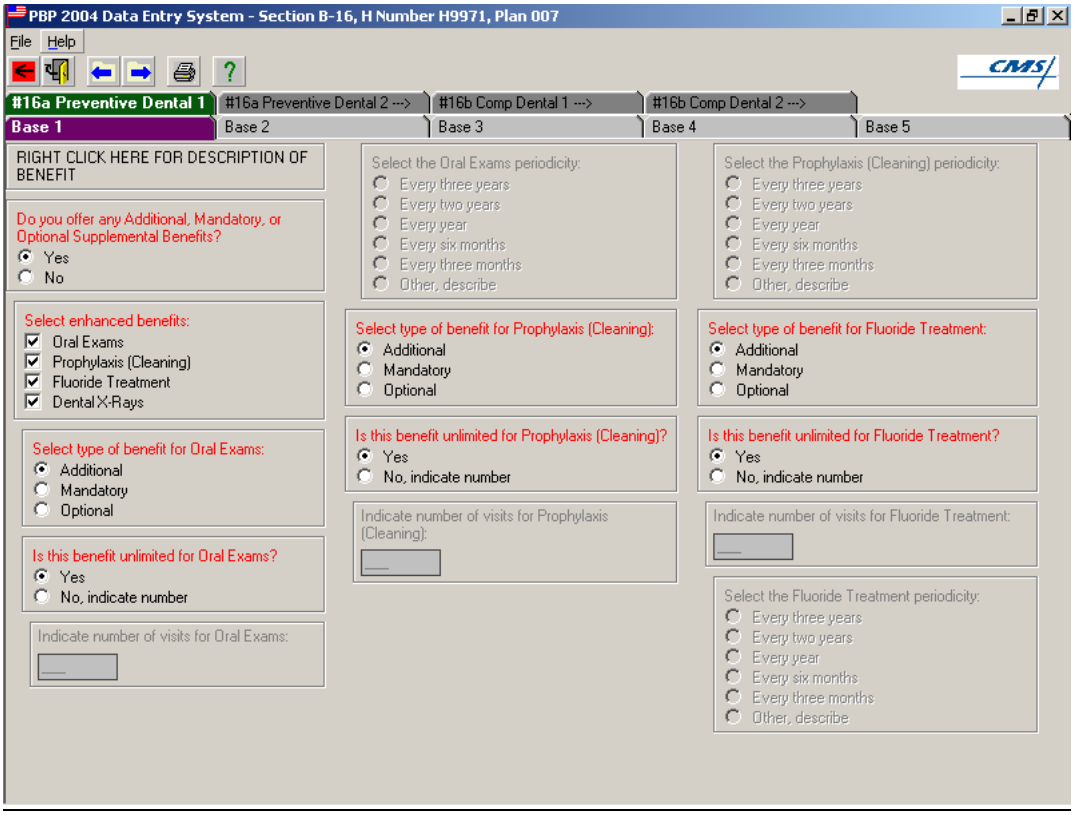
PBP B-16a: Preventive Dental Services

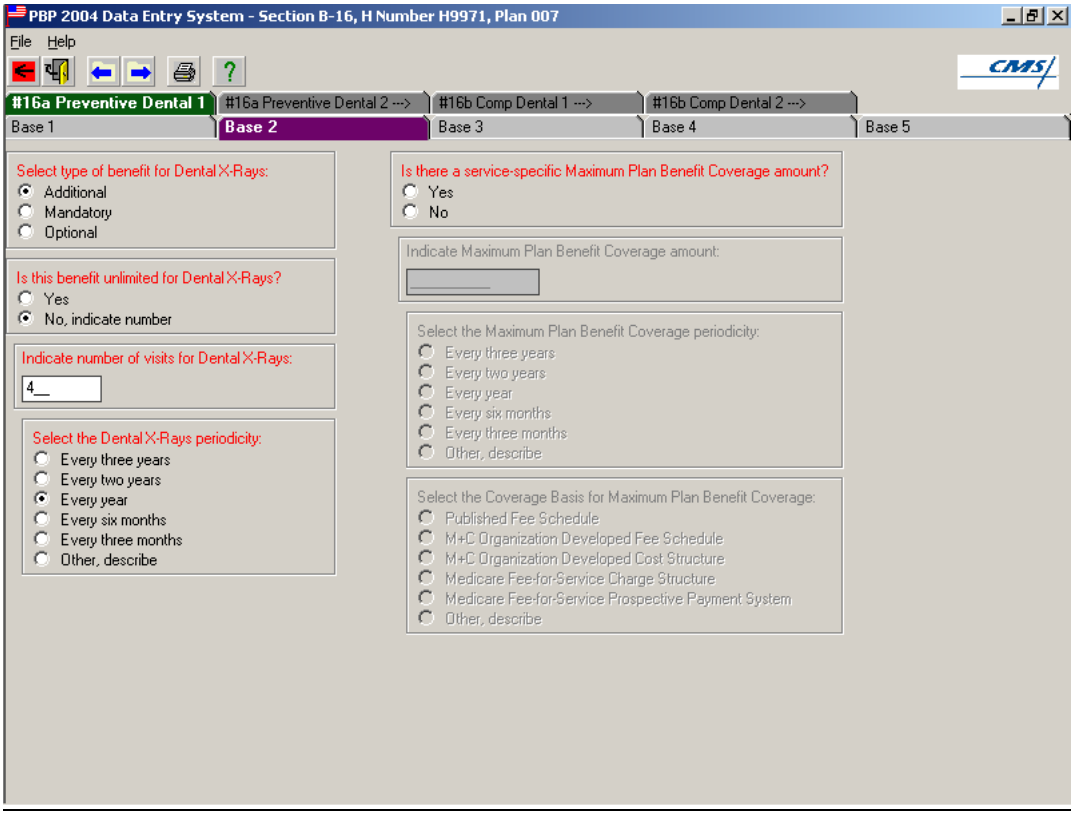
SB 29: Dental Services

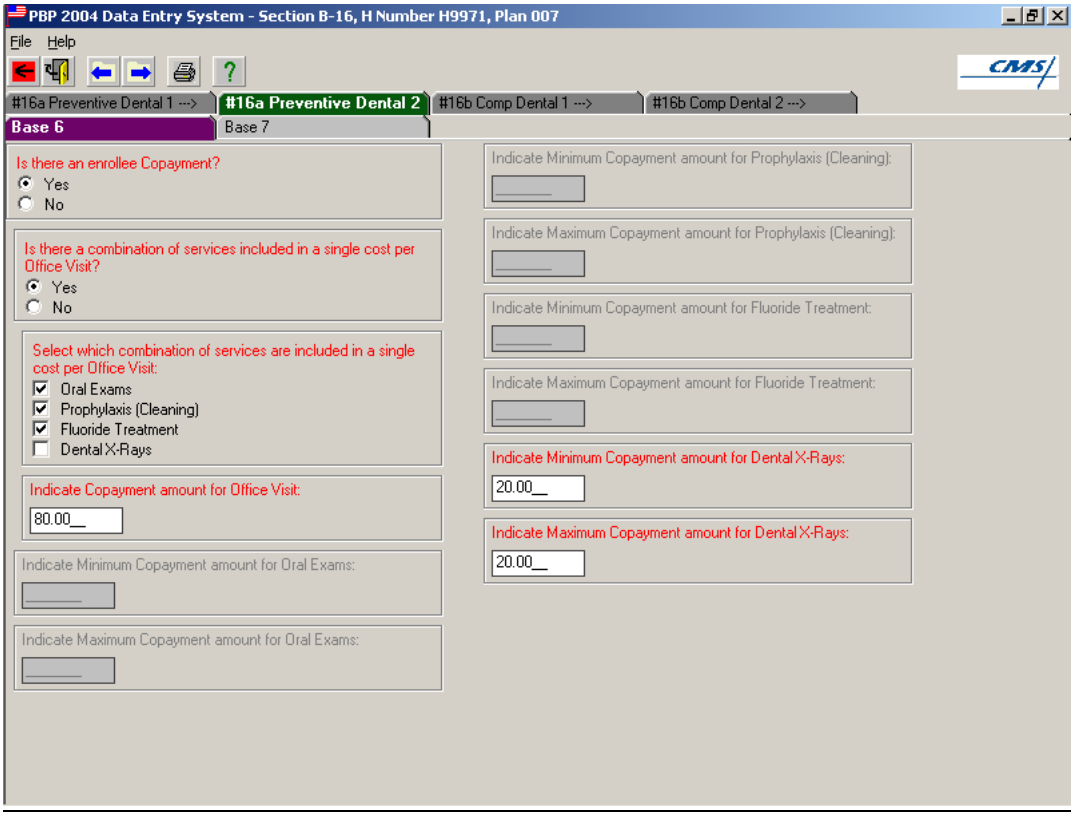
This category collects information on enhanced dental benefits offered by the plan.

The MCO can have a single cost share for an Office Visit and designate the enhanced benefits that are included in that Office Visit.

HELPFUL HINT:
If the plan offers Oral Exams, Fluoride Treatments, Cleanings, and X-rays, and an Office Visit costs $80 and is comprised of an Oral Exam, Fluoride Treatment, and Cleaning, then under the Copayment, the MCO should select "Yes" to the question, "Is there a combination of services included in a single cost per office visit?". The MCO should then select Oral Exams, Fluoride Treatments, and Cleanings for the combination, and then enter $80 as the copayment amount for the office visit. Since the plan also offers X-rays for $20 per visit up to 4 visits per year, the cost sharing for this benefit should be entered separately.







The SB includes bullets describing the benefits that are included in the Office Visit.

Data elements in the Preventive Dental and Comprehensive Dental categories allow for a maximum plan benefit coverage for either preventive dental, comprehensive dental, an

individual maximum plan benefit coverage for each category, or a combined maximum plan benefit coverage for both categories.

HELPFUL HINT:
See Section "PBP B-17a: Eye Exams, SB 31: Vision Services" below for further detailed information.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-16b: Comprehensive Dental

SB 29: Dental Services

This category collects information on Medicare-covered and non-Medicare-covered dental benefits offered by the plan.

HELPFUL HINT:
Whether an MCO answers, "Yes" **or** "No" to the question "Do you offer any Additional, Mandatory, or Optional Supplemental Benefits?" a couple (Blue colored) questions are available to be answered in Bases 3, 4, 6, 7, 8. These questions pertain to the Medicare covered benefit for Comprehensive Dental Services, which are required by Law to offer. If these questions are not answered, it will produce an error message and the MCO will **not** be allowed to upload.

Data elements in the Preventive Dental and Comprehensive Dental categories allow for a maximum plan benefit coverage for either preventive dental, comprehensive dental, an individual maximum plan benefit coverage for each category, or a combined maximum plan benefit coverage for both categories.

HELPFUL HINT:
See Section "PBP B-17a: Eye Exams, SB 31: Vision Services" below for further detailed information.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-17a: Eye Exams

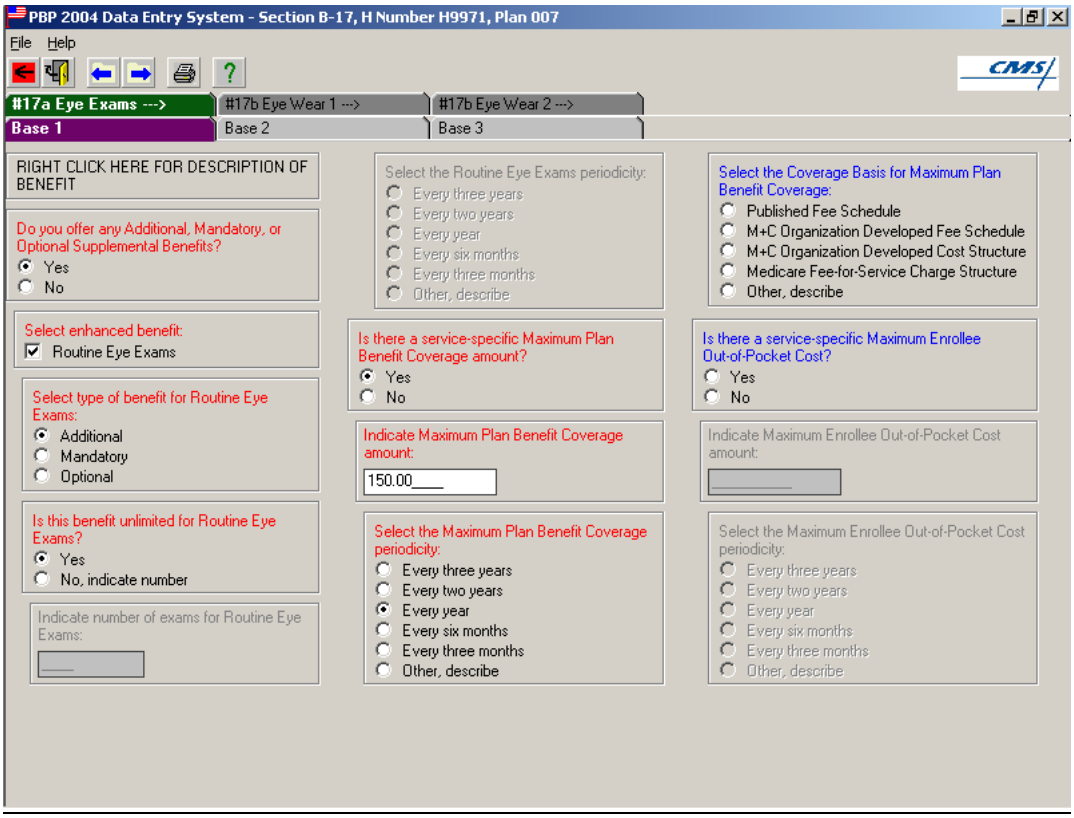
SB 31: Vision Services

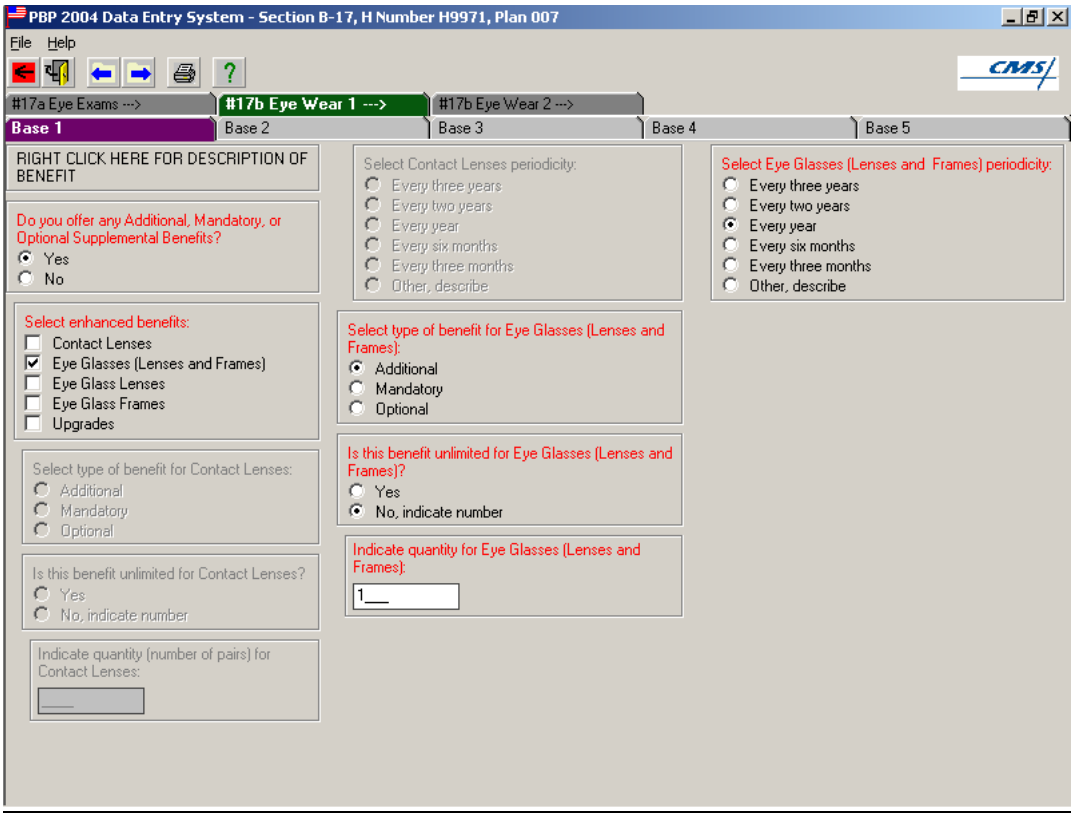
This category collects information on Medicare-covered and non-Medicare-covered vision services offered by the plan.

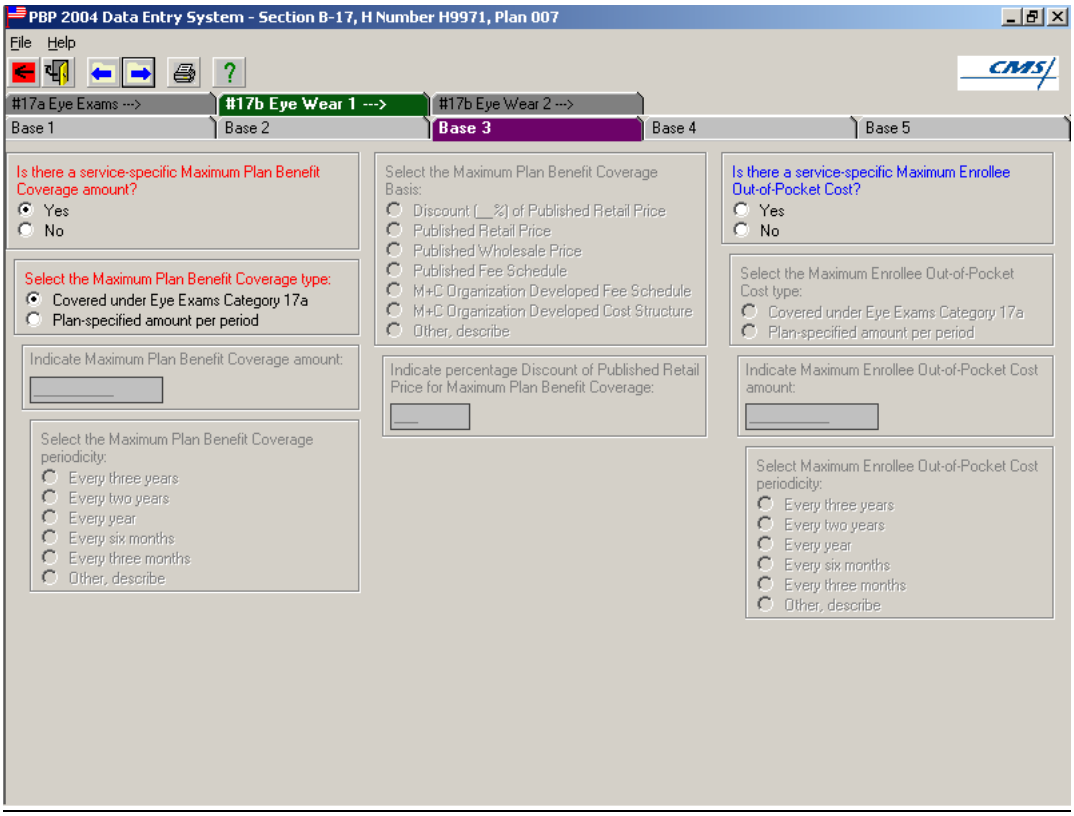
Data elements in the Eye Exam and Eye Wear categories allow for a maximum plan benefit coverage for either eye wear, eye exams, an individual maximum plan benefit coverage for each category, or a combined maximum plan benefit coverage for both categories.

HELPFUL HINT:
A plan offers a $150 annual maximum plan benefit coverage for eye care. This includes both 17a-Eye Exams and 17b-Eye Wear. In 17a-Eye Exams Base 1, select "Yes" to "Is there a service-specific Maximum Plan Benefit Coverage amount?", enter $150 and select "Every year".

In 17b-Eye Wear Base 3, select "Yes" to "Is there a service-specific Maximum Plan Benefit Coverage amount?", and for the next question, "Select the Maximum Plan Benefit Coverage type", select the option "Covered under Eye Exams Category 17a".







SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-17b: Eye Wear

SB 31: Vision Services

This category collects information on Medicare-covered and non-Medicare-covered eyewear benefits offered by the plan.

Data elements in the Eye Exam and Eye Wear categories allow for a maximum plan benefit coverage for either eye wear, eye exams, an individual maximum plan benefit coverage for each category, or a combined maximum plan benefit coverage for both categories.

HELPFUL HINT:
See Section "PBP B-17a: Eye Exams, SB 31: Vision Services" above for further detailed information.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

PBP B-18a: Hearing Exams

SB 30: Hearing Services

This category collects information on Medicare-covered and non-Medicare-covered hearing services offered by the plan.

Data elements in the Hearing Exams and Hearing Aids categories allow for a maximum plan benefit coverage for either preventive dental, comprehensive dental, an individual maximum plan benefit coverage for each category, or a combined maximum plan benefit coverage for both categories.

HELPFUL HINT:
See Section "PBP B-17a: Eye Exams, SB 31: Vision Services" above for further detailed information.

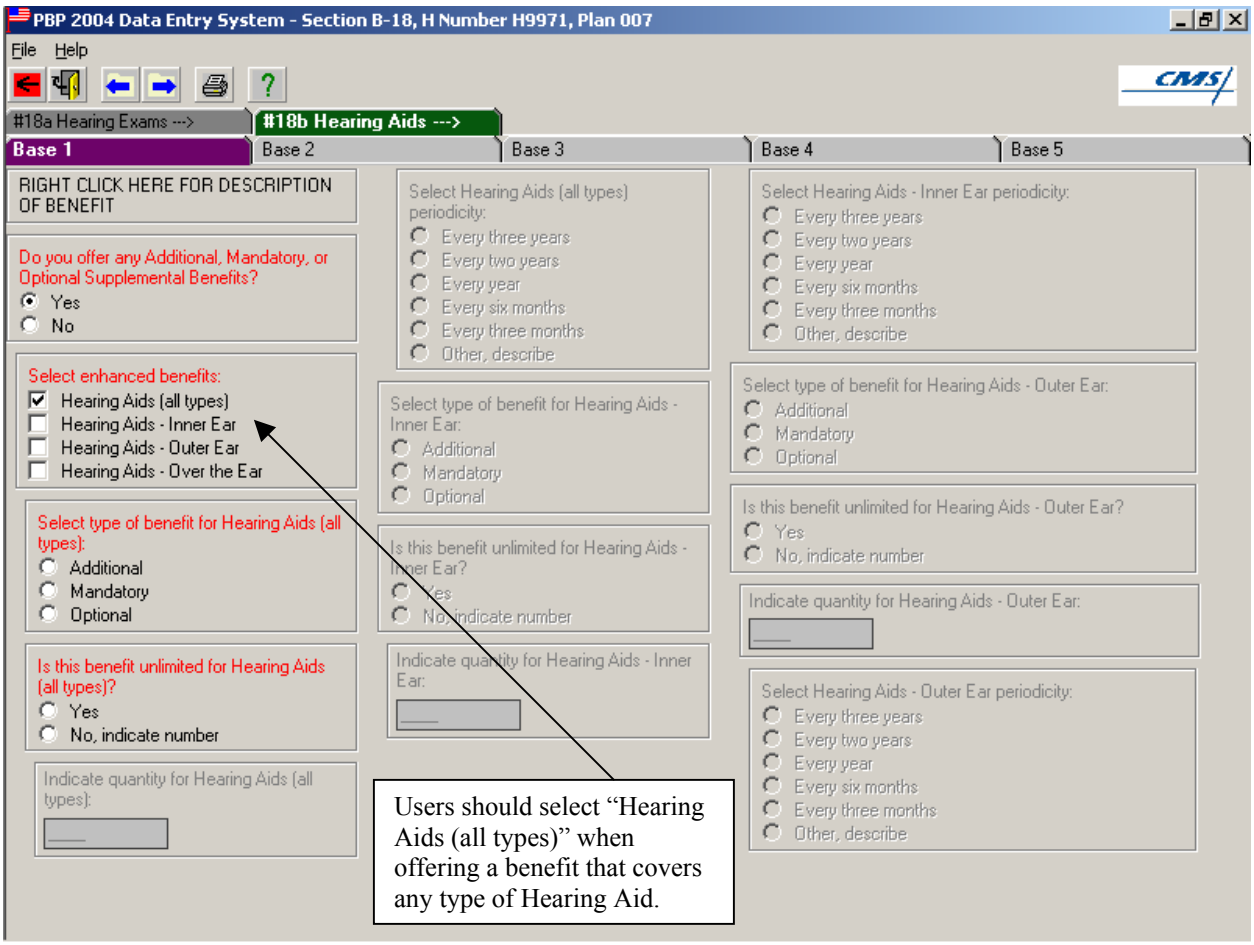
SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

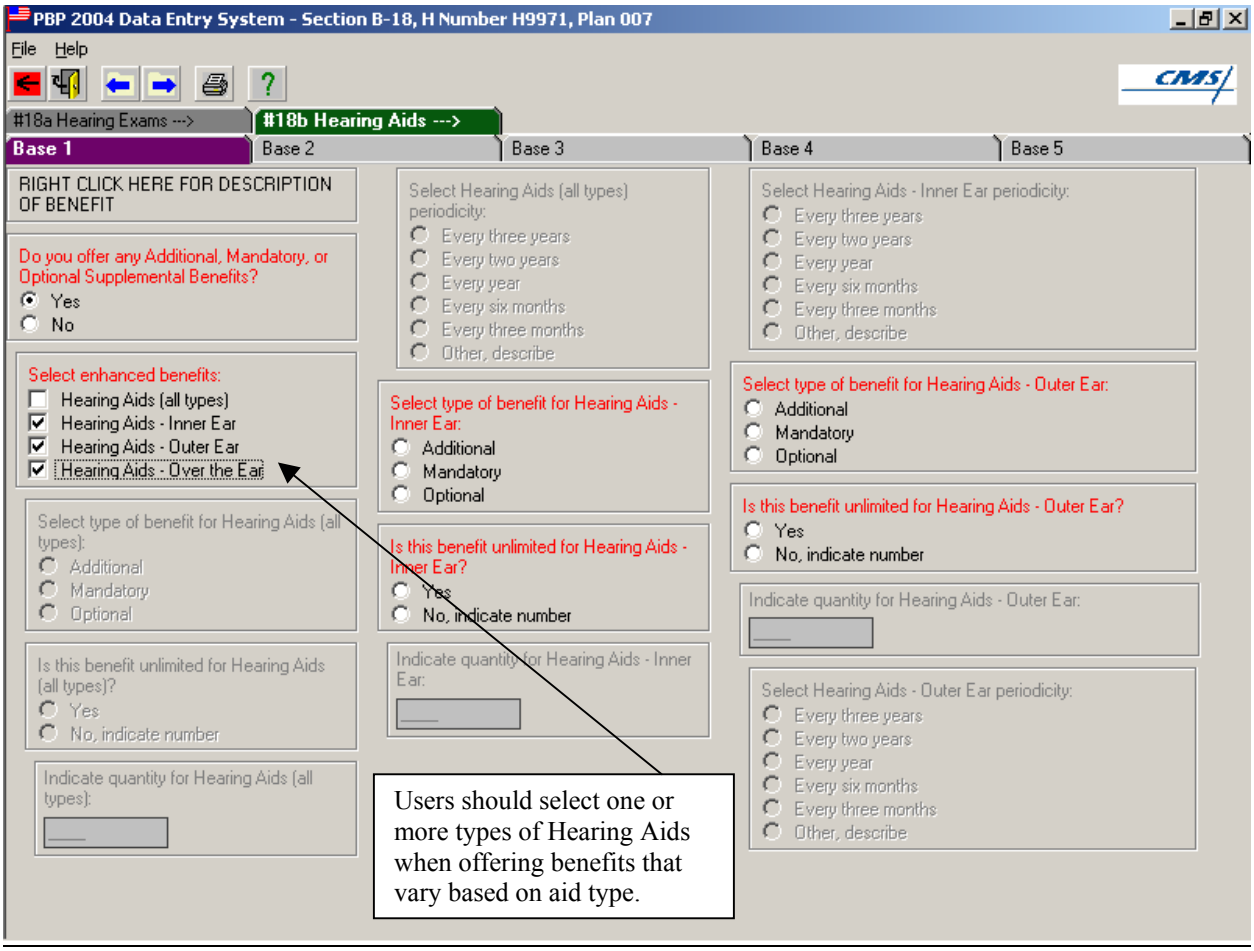
PBP B-18b: Hearing Aids

SB 30: Hearing Services

This category collects information on Medicare-covered and non-Medicare-covered hearing benefits offered by the plan.

HELPFUL HINT:
For enhanced benefits, the plan may select Hearing Aids (all types) **OR** one or more of the individual types of aids (Inner Ear, Outer Ear, and/or Over the Ear). If Hearing Aids (all types) is selected, then the MCO may NOT select an individual type of aid. There is a min/max cost share available for the plan to price Hearing Aids (all types).





Data elements in the Preventive Dental and Comprehensive Dental categories allow for a maximum plan benefit coverage for either preventive dental, comprehensive dental, an individual maximum plan benefit coverage for each category, or a combined maximum plan benefit coverage for both categories.

HELPFUL HINT:
See Section "PBP B-17a: Eye Exams, SB 31: Vision Services" above for further detailed information.

SB Out-of-Network sentences for PPOs may be generated based on data entered in Section C for out-of-network benefits.

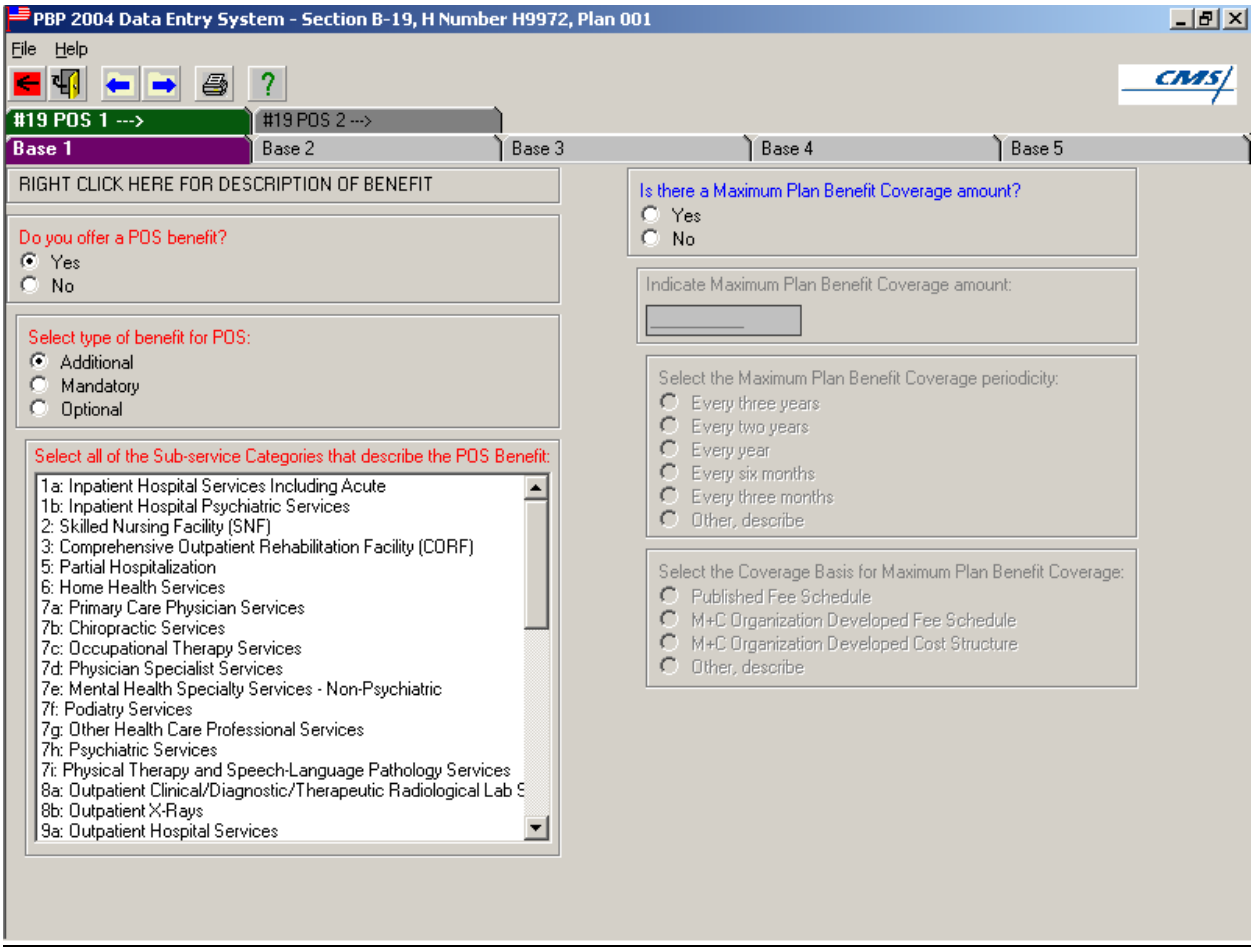
PBP B-19: POS

SB 36: Point of Service

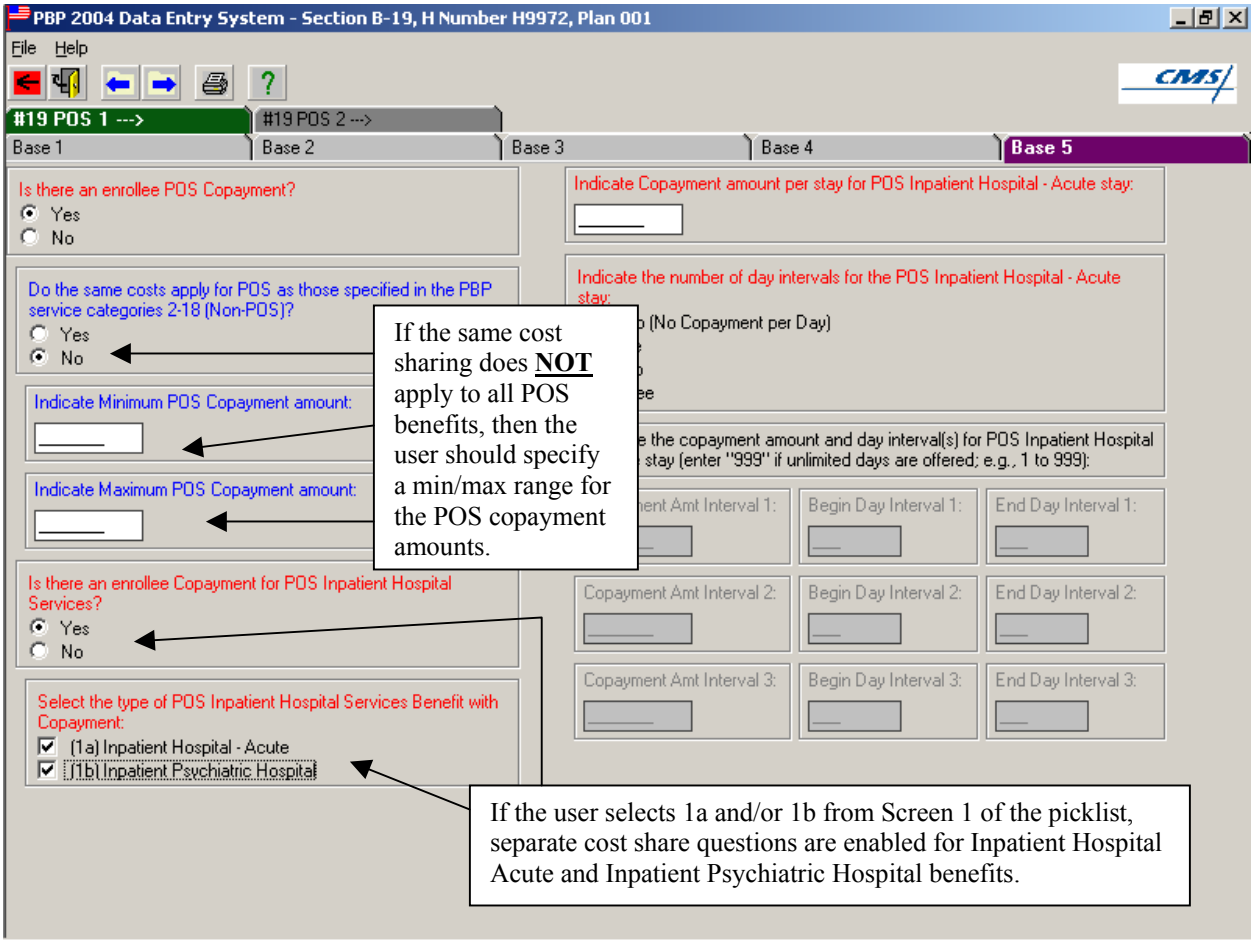
This category collects information on non-Medicare-covered point-of-service benefits offered by the plan.

NOTE: This category is not enabled for HMO plan types.

The POS category includes pick lists to enable the MCO to indicate which service categories describe the POS benefit and, in addition, which of those categories require a referral and which require authorization.



If the plan indicates that there is a cost share for the POS benefit, the PBP allows the MCO to indicate if the POS costs are the same as non-POS, or if they are different by entering a Min/Max range.


PBP 2004 Data Entry System - Section B-19, H Number H9972, Plan 001
File Help
#19 POS 1 --->
#19 POS 2 --->
Base 1
Base 2
Base 3
Base 4
Base 5
Is there an enrollee POS Copayment?
Yes
No
Do the same costs apply for POS as those specified in the PBP service categories 2-18 (Non-POS)?
Yes
No
Indicate Minimum POS Copayment amount:
Indicate Maximum POS Copayment amount:
Is there an enrollee Copayment for POS Inpatient Hospital Services?
Yes
No
Select the type of POS Inpatient Hospital Services Benefit with Copayment:
(1a) Inpatient Hospital - Acute
(1b) Inpatient Psychiatric Hospital
Indicate Copayment amount per stay for POS Inpatient Hospital - Acute stay:
Indicate the number of day intervals for the POS Inpatient Hospital - Acute stay:
(No Copayment per Day)
stay (enter "999" if unlimited days are offered; e.g., 1 to 999):
Begin Day Interval 1:
End Day Interval 1:
Copayment Amt Interval 2:
Begin Day Interval 2:
End Day Interval 2:
Copayment Amt Interval 3:
Begin Day Interval 3:
End Day Interval 3:
If the same cost sharing does NOT apply to all POS benefits, then the user should specify a min/max range for the POS copayment amounts.
If the user selects 1a and/or 1b from Screen 1 of the picklist, separate cost share questions are enabled for Inpatient Hospital Acute and Inpatient Psychiatric Hospital benefits.

Prior to CY 2004, Section C was used to describe a plan's

- Exclusions and restrictions of plan coverage;
- Access to providers; and
- Provision of services to dual (Medicare & Medicaid) eligible beneficiaries.

Beginning in CY 2004, Section C is only available to PPO (Preferred Provider Organization) plan types, which includes PPO, PPO Alternative Pay Demo, and PPO Demo.

Section C collects out-of-network benefit information by service category. This information includes: maximum plan benefit coverage, maximum enrollee out-of-pocket costs, coinsurance, deductible, copayment, authorization, and referral. Section C-4 is an optional Notes field provided for the plan to enter any additional information not captured in the data entry fields pertaining to Section C.

To begin data entry, click on the command button located beneath Section C. This command button will display three possible states of data entry. These include:

- **<New>** -- Section C has not been opened for data entry.
- **<Incomplete>** -- Data entry has begun and has not been completed.
- **<Completed>** -- Data entry has been completed.

The status of Section C (e.g., New, Incomplete, and Completed) appears directly on the command button.

Once data entry has been completed and validated for Section C, the Status on the command button will display Completed**.** The color of the section heading *Step 3: Complete Section C* will change from **red** to **black** to help indicate Section C is completed.

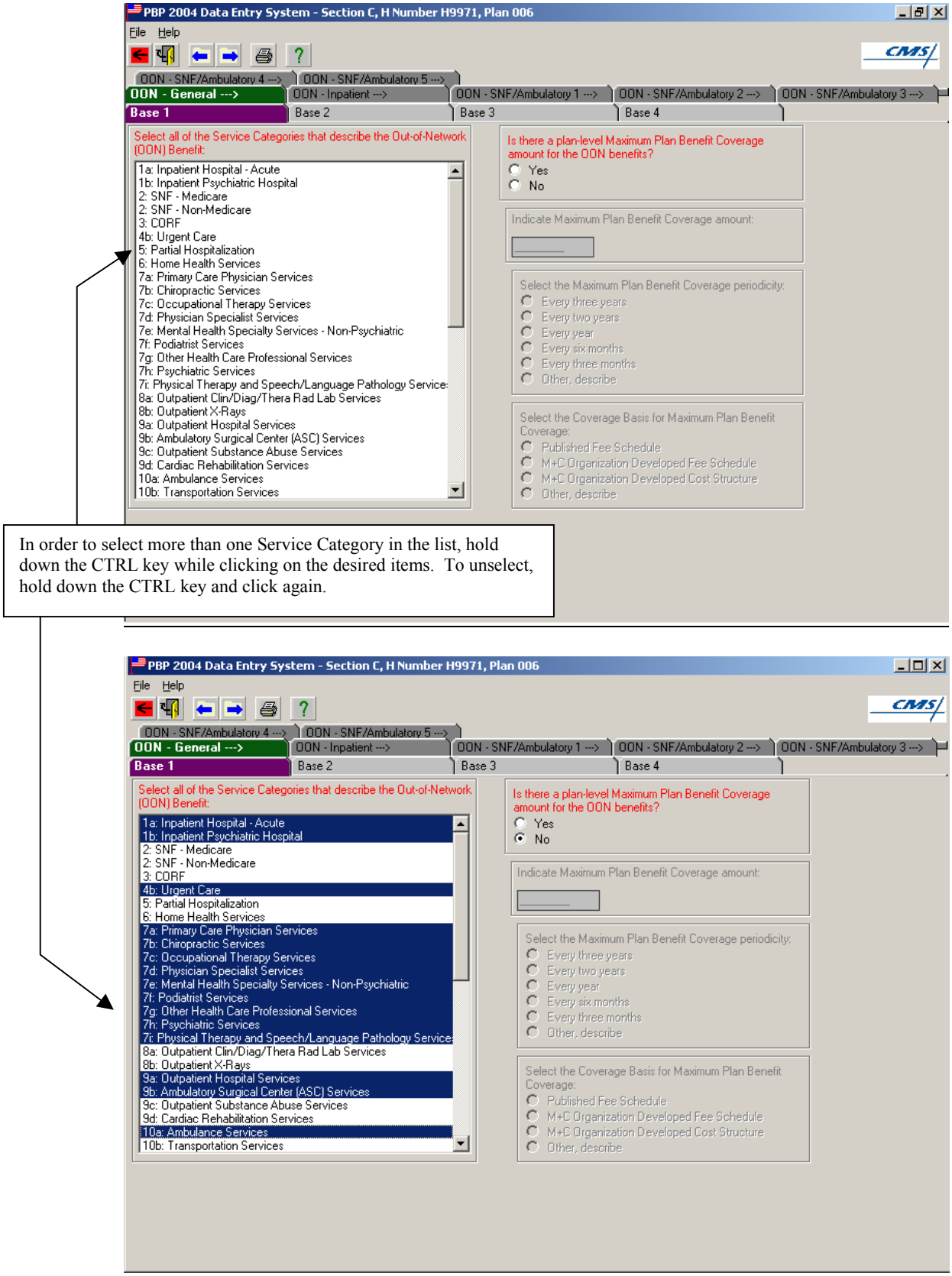
PPO Out-of-Network Benefits

For PBP 2004, Section C now contains questions that PPO plans should use to describe their Out-of Network benefits. Generally, an out-of-network benefit provides a beneficiary with the option to access plan services outside of the plan's contracted network of providers. In some cases, a beneficiary's out-of-pocket costs may be higher for an out-of-network benefit.

Section C provides questions for the MCO to describe it's overall plan-level Out-of-Network benefit, detailed questions for out-of-network inpatient hospital benefits, and up to five sets of questions that can be used to describe Out-of-Network SNF and Outpatient benefits. A picklist of PBP categories (excluding Emergency Care) is provided for the MCO to select which services are included as part of the Out-of-Network benefit.

On the Base set of screens, the plan should select from the picklist which categories of benefits are offered out-of-network, and describe the maximum plan benefit coverage, enrollee out-of-pocket maximum costs, and deductible for these out-of-network benefits, if applicable. If the plan offers out-of-network inpatient hospital benefits, those should be described on the Out-of-Network Inpatient Hospital screens.

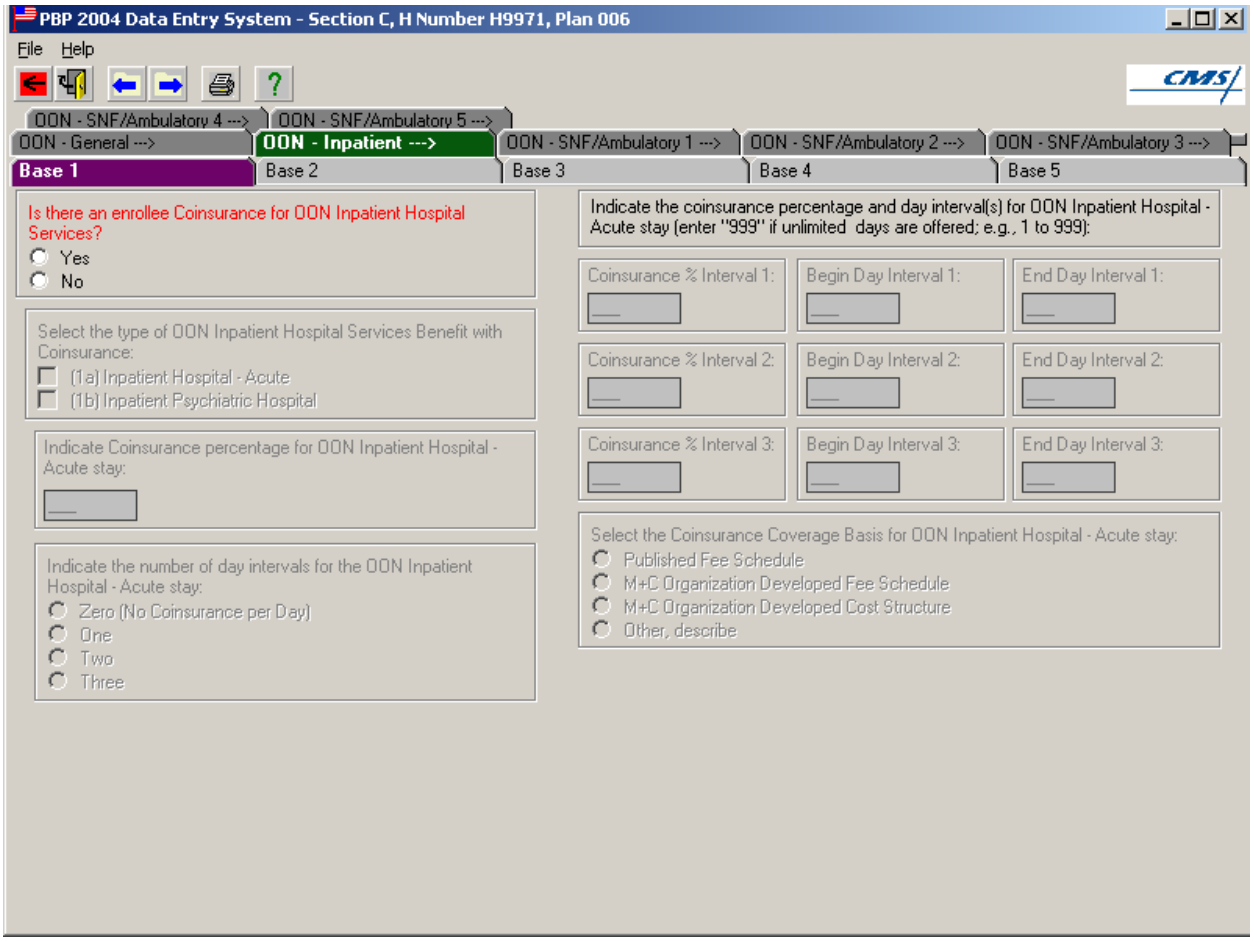
Individual or grouped Out-of-network SNF and Outpatient benefits should be described on the SNF/Outpatient screens. The plan may describe up to five sets of these benefits. A picklist of PBP categories (excluding Emergency Care) is provided for the MCO to select which services are included as part of each set of Out-of-Network benefits.



In order to select more than one Service Category in the list, hold down the CTRL key while clicking on the desired items. To unselect, hold down the CTRL key and click again.

HELPFUL HINT:
Users will notice that benefit categories 4a: Emergency Care and 19: Point of Service are not included in the drop down list. Beneficiaries cannot be charged differently out of network than in network for Emergency services.

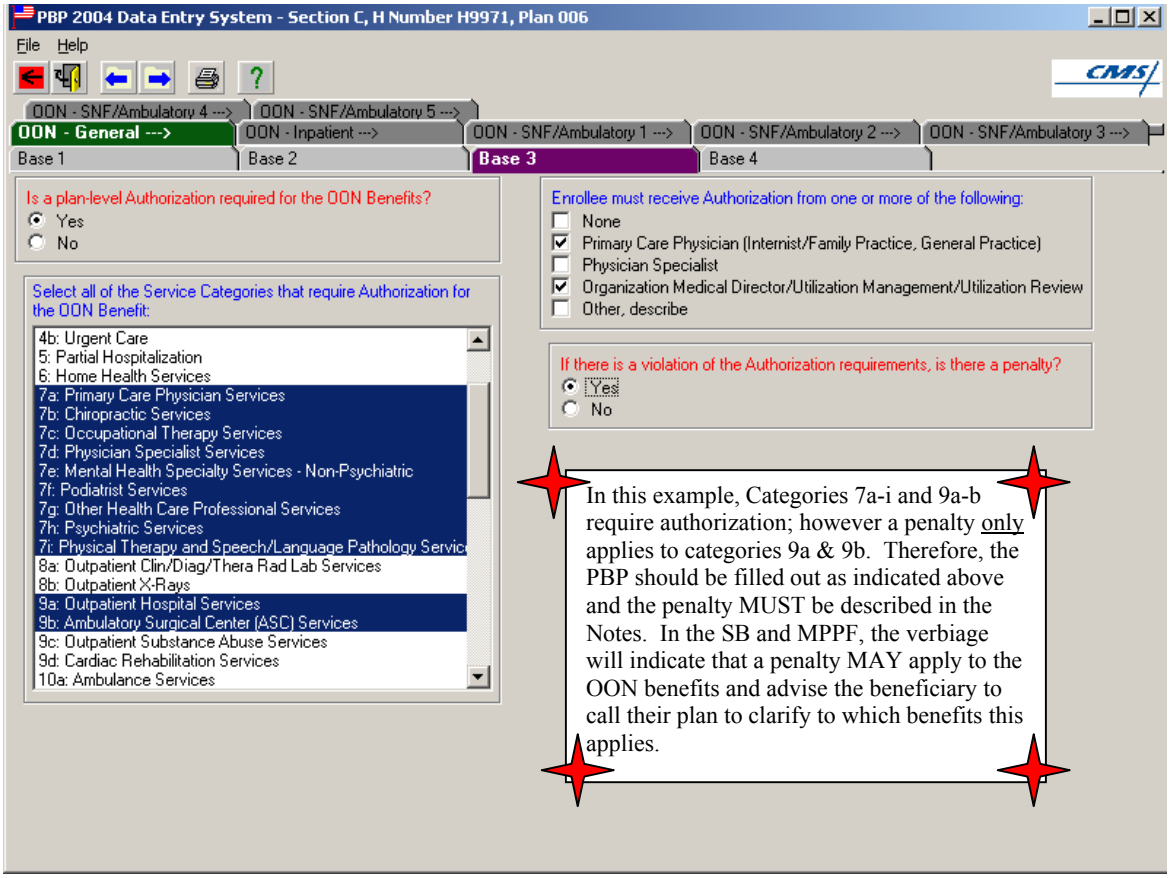
- If the MCO selects the Inpatient Hospital benefit on the "OON – General" tab, the "OON – Inpatient" tab be available for data entry for the Inpatient Hospital benefit ONLY.

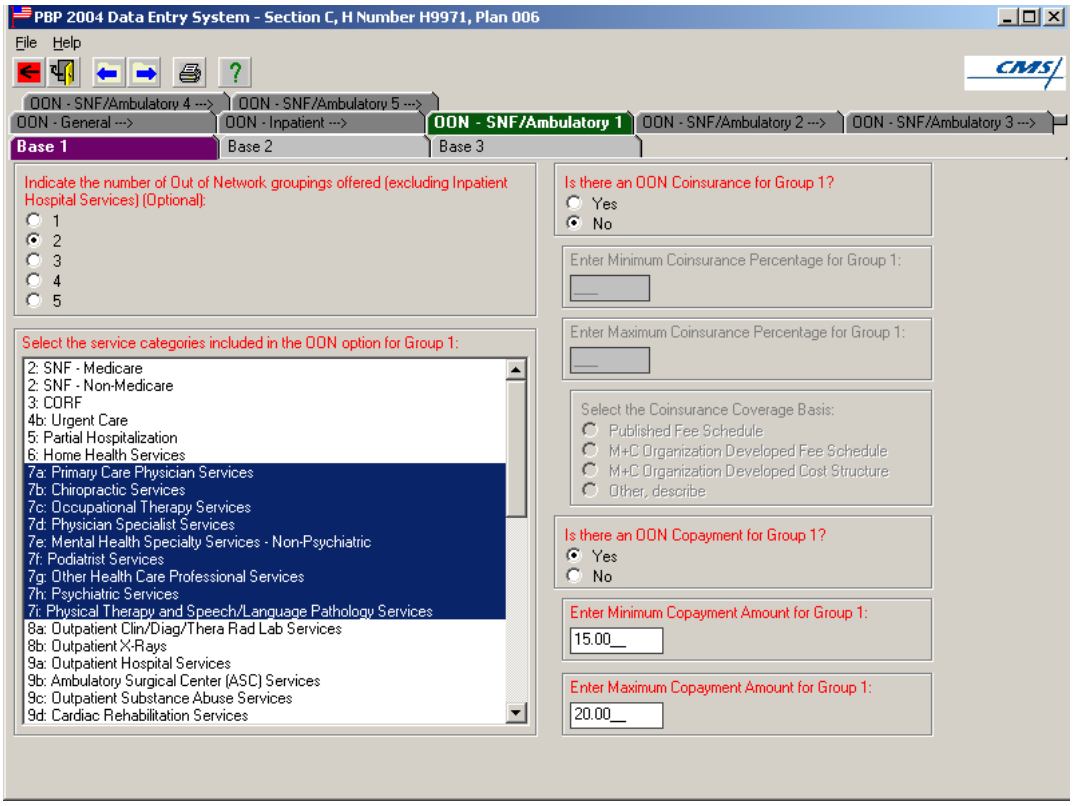


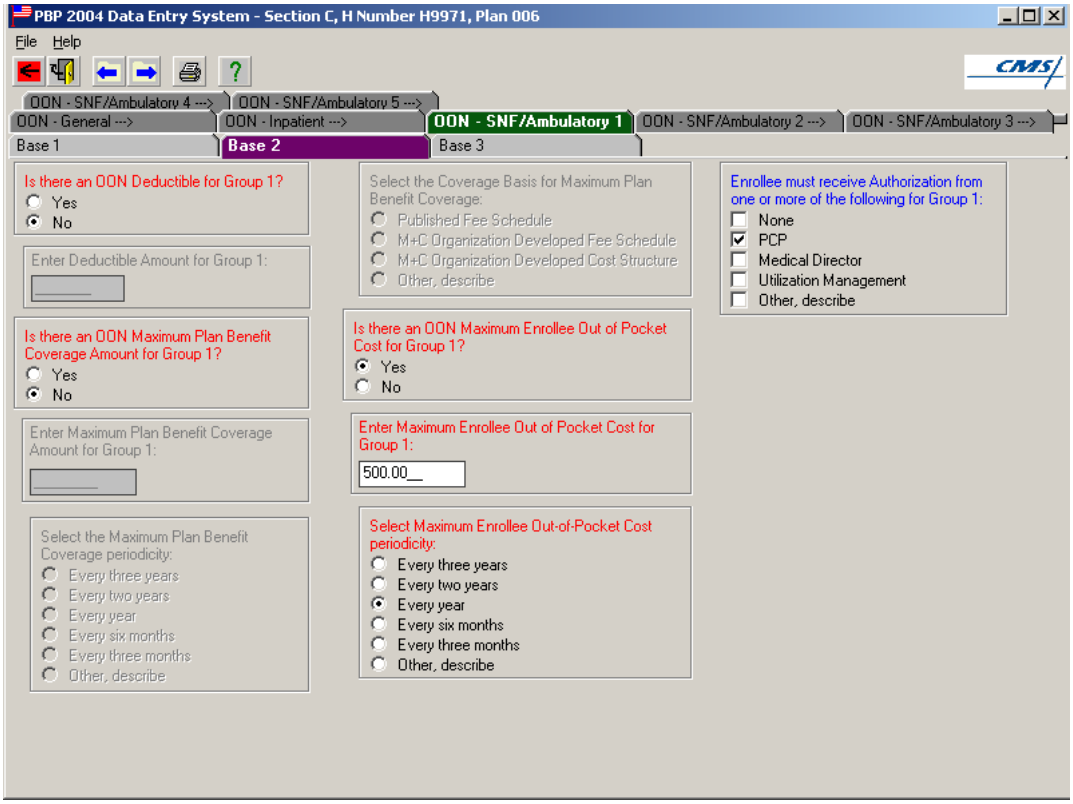
- If an MCO selects OON benefits other than Inpatient Hospital, then the MCO can categorize one or more benefits into a "Group".
  - With a maximum of 5 Groups, the MCO can form groups based on various copay/coinsurance structures, Deductibles, Max Plan Benefit Coverage Amounts, Max Enrollee Out of Pocket Costs, and Authorization requirements.
    - CMS recommends developing the least number of "groups" by attempting to arrange the benefits together having like benefit structures.
    - For example, if an MCO wants to offer the following benefit structure:
      - OON Health Care Professional Services benefit with:
        - $15 PCP copay per visit
        - $20 Specialist copay per visit
        - $500 annual Max Enrollee Out of Pocket Cost
        - PCP authorization for visits to a Specialist
      - OON Outpatient Hospital Services benefit with:
        - $100 copay per visit for Outpatient Hospital Services and ASC Services
        - $1,500 Deductible
        - PCP & Medical Director authorization for visits is required **AND** a penalty applies if the authorization is not met

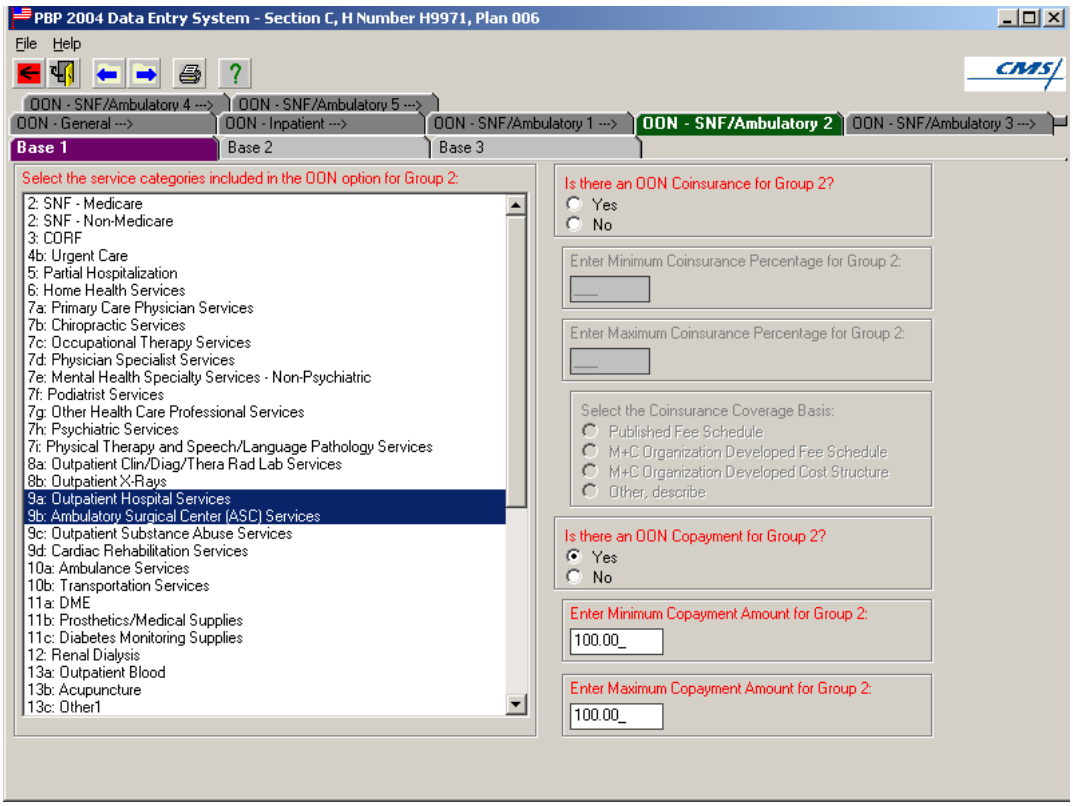
The input screens would be filled in as follows with two (2) "Groups":

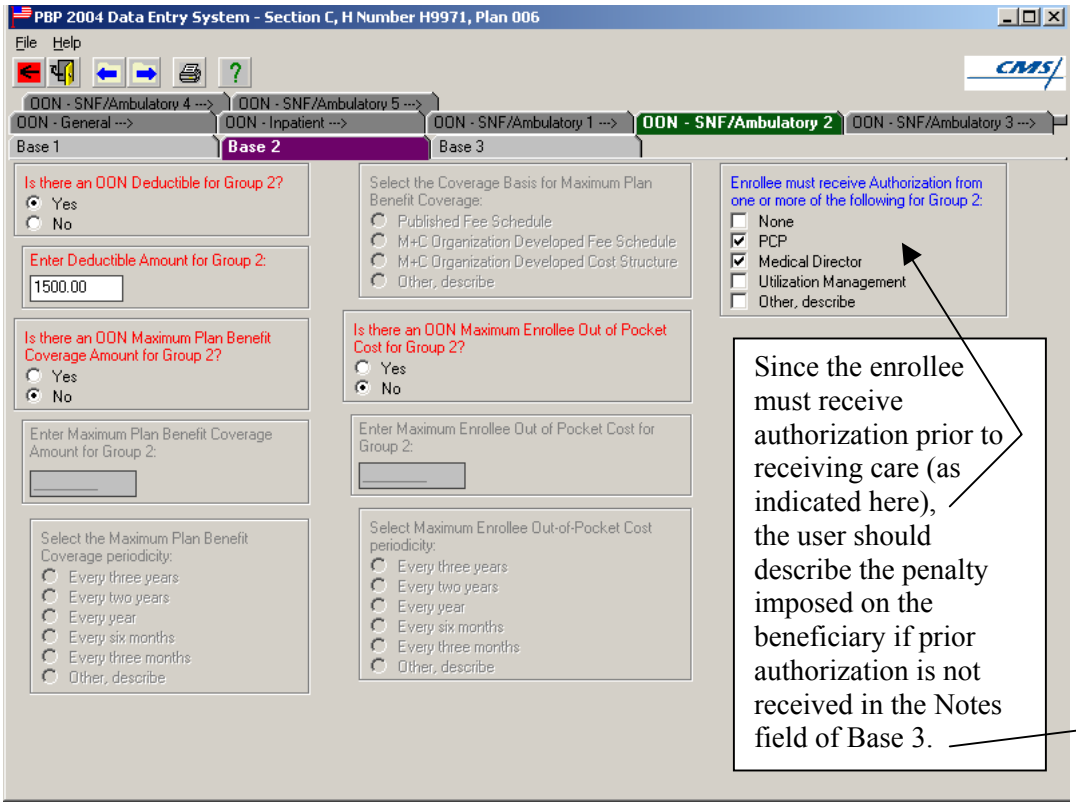
All additional information pertaining to the benefit (especially the authorization requirements) should be entered in "General - Base 3" or in the respective section.

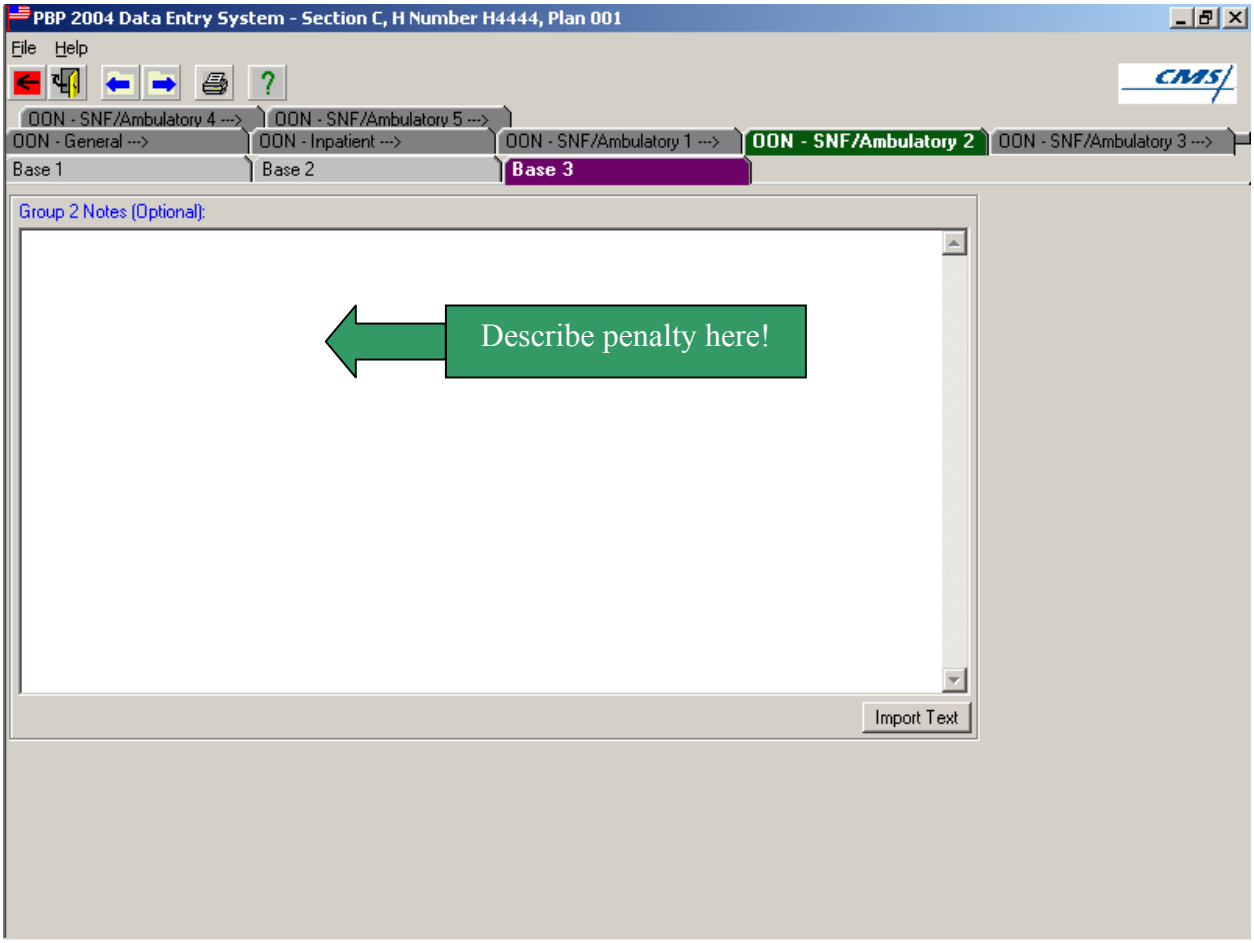



PBP 2004 Data Entry System - Section C, H Number H9971, Plan 006
File Help
CMS
OON - SNF/Ambulatory 4 --->
OON - SNF/Ambulatory 5 --->
OON - General --->
OON - Inpatient --->
OON - SNF/Ambulatory 1
OON - SNF/Ambulatory 2 --->
OON - SNF/Ambulatory 3 --->
Base 1
Base 2
Base 3
Indicate the number of Out of Network groupings offered (excluding Inpatient Hospital Services) (Optional):
1
2
3
4
5
Select the service categories included in the OON option for Group 1:
2: SNF - Medicare
2: SNF - Non-Medicare
3: CORF
4b: Urgent Care
5: Partial Hospitalization
6: Home Health Services
7a: Primary Care Physician Services
7b: Chiropractic Services
7c: Occupational Therapy Services
7d: Physician Specialist Services
7e: Mental Health Specialty Services - Non-Psychiatric
7f: Podiatrist Services
7g: Other Health Care Professional Services
7h: Psychiatric Services
7i: Physical Therapy and Speech/Language Pathology Services
8a: Outpatient Clin/Diag/Thera Rad Lab Services
8b: Outpatient X-Rays
9a: Outpatient Hospital Services
9b: Ambulatory Surgical Center (ASC) Services
9c: Outpatient Substance Abuse Services
9d: Cardiac Rehabilitation Services
Is there an OON Coinsurance for Group 1?
Yes
No
Enter Minimum Coinsurance Percentage for Group 1:
Enter Maximum Coinsurance Percentage for Group 1:
Select the Coinsurance Coverage Basis:
Published Fee Schedule
M+C Organization Developed Fee Schedule
M+C Organization Developed Cost Structure
Other, describe
Is there an OON Copayment for Group 1?
Yes
No
Enter Minimum Copayment Amount for Group 1:
15.00
Enter Maximum Copayment Amount for Group 1:
20.00


PBP 2004 Data Entry System - Section C, H Number H9971, Plan 006
File Help
CMS
OON - SNF/Ambulatory 4 --->
OON - SNF/Ambulatory 5 --->
OON - General --->
OON - Inpatient --->
OON - SNF/Ambulatory 1
OON - SNF/Ambulatory 2 --->
OON - SNF/Ambulatory 3 --->
Base 1
Base 2
Base 3
Is there an OON Deductible for Group 1?
Yes
No
Enter Deductible Amount for Group 1:
Is there an OON Maximum Plan Benefit Coverage Amount for Group 1?
Yes
No
Enter Maximum Plan Benefit Coverage Amount for Group 1:
Select the Maximum Plan Benefit Coverage periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Select the Coverage Basis for Maximum Plan Benefit Coverage:
Published Fee Schedule
M+C Organization Developed Fee Schedule
M+C Organization Developed Cost Structure
Other, describe
Is there an OON Maximum Enrollee Out of Pocket Cost for Group 1?
Yes
No
Enter Maximum Enrollee Out of Pocket Cost for Group 1:
500.00
Select Maximum Enrollee Out-of-Pocket Cost periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Enrollee must receive Authorization from one or more of the following for Group 1:
None
PCP
Medical Director
Utilization Management
Other, describe


PBP 2004 Data Entry System - Section C, H Number H9971, Plan 006
File Help
OON - SNF/Ambulatory 4 --->
OON - SNF/Ambulatory 5 --->
OON - General --->
OON - Inpatient --->
OON - SNF/Ambulatory 1 --->
OON - SNF/Ambulatory 2
OON - SNF/Ambulatory 3 --->
Base 1
Base 2
Base 3
Select the service categories included in the OON option for Group 2:
2: SNF - Medicare
2: SNF - Non-Medicare
3: CORF
4b: Urgent Care
5: Partial Hospitalization
6: Home Health Services
7a: Primary Care Physician Services
7b: Chiropractic Services
7c: Occupational Therapy Services
7d: Physician Specialist Services
7e: Mental Health Specialty Services - Non-Psychiatric
7f: Podiatrist Services
7g: Other Health Care Professional Services
7h: Psychiatric Services
7i: Physical Therapy and Speech/Language Pathology Services
8a: Outpatient Clin/Diag/Thera Rad Lab Services
8b: Outpatient X-Rays
9a: Outpatient Hospital Services
9b: Ambulatory Surgical Center (ASC) Services
9c: Outpatient Substance Abuse Services
9d: Cardiac Rehabilitation Services
10a: Ambulance Services
10b: Transportation Services
11a: DME
11b: Prosthetics/Medical Supplies
11c: Diabetes Monitoring Supplies
12: Renal Dialysis
13a: Outpatient Blood
13b: Acupuncture
13c: Other1
Is there an OON Coinsurance for Group 2?
Yes
No
Enter Minimum Coinsurance Percentage for Group 2:
Enter Maximum Coinsurance Percentage for Group 2:
Select the Coinsurance Coverage Basis:
Published Fee Schedule
M+C Organization Developed Fee Schedule
M+C Organization Developed Cost Structure
Other, describe
Is there an OON Copayment for Group 2?
Yes
No
Enter Minimum Copayment Amount for Group 2:
100.00_
Enter Maximum Copayment Amount for Group 2:
100.00_


PBP 2004 Data Entry System - Section C, H Number H9971, Plan 006
File Help
OON - SNF/Ambulatory 4 --->
OON - SNF/Ambulatory 5 --->
OON - General --->
OON - Inpatient --->
OON - SNF/Ambulatory 1 --->
OON - SNF/Ambulatory 2
OON - SNF/Ambulatory 3 --->
Base 1
Base 2
Base 3
Is there an OON Deductible for Group 2?
Yes
No
Enter Deductible Amount for Group 2:
1500.00
Is there an OON Maximum Plan Benefit Coverage Amount for Group 2?
Yes
No
Enter Maximum Plan Benefit Coverage Amount for Group 2:
Select the Maximum Plan Benefit Coverage periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Select the Coverage Basis for Maximum Plan Benefit Coverage:
Published Fee Schedule
M+C Organization Developed Fee Schedule
M+C Organization Developed Cost Structure
Other, describe
Is there an OON Maximum Enrollee Out of Pocket Cost for Group 2?
Yes
No
Enter Maximum Enrollee Out of Pocket Cost for Group 2:
Select Maximum Enrollee Out-of-Pocket Cost periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Enrollee must receive Authorization from one or more of the following for Group 2:
None
PCP
Medical Director
Utilization Management
Other, describe
Since the enrollee must receive authorization prior to receiving care (as indicated here), the user should describe the penalty imposed on the beneficiary if prior authorization is not received in the Notes field of Base 3.


PBP 2004 Data Entry System - Section C, H Number H4444, Plan 001
File
Help
CMS
OON - SNF/Ambulatory 4 --->
OON - SNF/Ambulatory 5 --->
OON - General --->
OON - Inpatient --->
OON - SNF/Ambulatory 1 --->
OON - SNF/Ambulatory 2
OON - SNF/Ambulatory 3 --->
Base 1
Base 2
Base 3
Group 2 Notes (Optional):
Describe penalty here!
Import Text

SECTION D

Section D collects plan-level cost sharing and limits designated for each of the individual plans. Cost sharing and limits include each plan's premium, deductible, maximum plan benefit coverage (i.e., plan expenditure limits), and maximum enrollee out-of-pocket costs. It is important to distinguish that Section D identifies plan-level cost sharing amounts, while Section B requests service-specific cost sharing amounts for each service category. It is recommended that Section B be completed prior to entering Section D. As certain items are entered in Section B, additional items are triggered in Section D for data entry. (i.e. – Optional Supplemental Benefits)

All supplemental benefits that were designated Optional in Section B must be associated with an Optional Premium in Section D before completing a plan's PBP. In addition, Section D requests that the user define the services and premiums for both individual and grouped optional supplemental benefits. A special set of screens is provided in each Optional Supplemental Benefit package for data entry of step-up benefits for ten selected subcategories:

- 7b-Chiropractic Services,
- 7f-Podiatry Services,
- 10b-Transportation,
- 15-Outpatient Prescription Drugs,
- 16a-Preventive Dental,
- 16b-Comprehensive Dental,
- 17a-Eye Exams,
- 17b-Eye Wear,
- 18a-Hearing Exams, and
- 18b-Hearing Aids.

If a plan's optional benefits package includes a step-up benefit for which there are no special step-up screens in Section D (not one of the ten selected subcategories), these step-up benefits must be described in the corresponding Notes field of the service category in Section B.

To begin data entry, click on the command button located beneath Section D. This command button will display three possible states of data entry. These include:

- **<New>** -- Section D has not been opened for data entry.
- **<Incomplete>** -- Data entry has begun and has not been completed.
- **<Completed>** -- Data entry has been completed.

Once data entry has been completed and validated for Section D, the Status on the command button will display Completed**.** The color of the section heading *Step 3: Complete Section D* will change from **red** to **black** to help indicate Section D is completed.

NOTE: Refer to the Perform Data Entry section of this manual for further details about Step-Ups (Optional Supplemental Benefits).

ORDI Plan Types

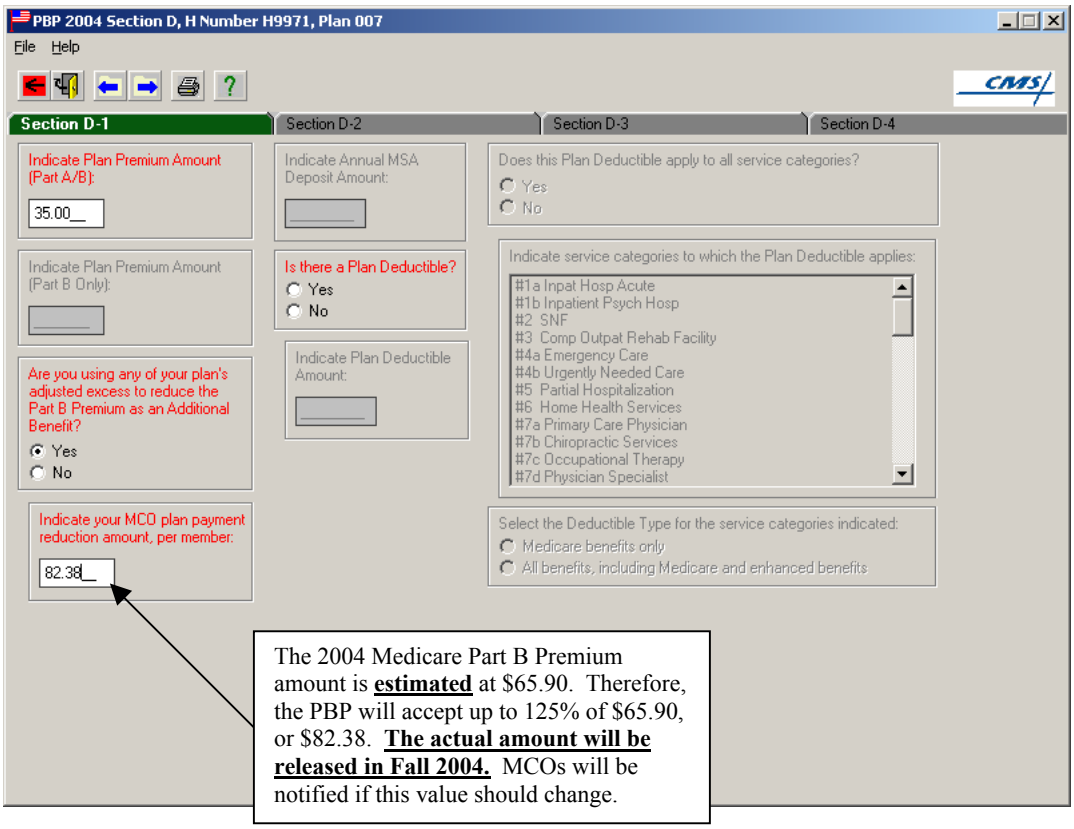
Section D is not applicable for ORDI (Office of Research, Development, and Information) plan types.

Part B Premium Reduction

Beginning in CY 2003, MCOs are able to use their adjusted excess to reduce the Part B premium for beneficiaries. Since the Medicare Part B premium for 2004 will not be released until the fall of 2003, the PBP (and ACR) use an estimated value of $65.90 for the 2004 Medicare Part B premium amount. This value may change after release of the PBP and ACR. If this value changes, CMS will notify your M+CO of the correct value for you to insert update in the PBP and ACR.

When offering this benefit, a plan cannot reduce its payment by more than 125 percent of the Medicare Part B premium, or $82.38 ($65.90*125%). As a result, the PBP system validates the "indicate your MCO plan payment reduction amount, per member" field to ensure that the number entered is not greater than 125 percent of the Medicare Part B premium.

In order to calculate the Part B premium reduction amount, the PBP system will multiply the number entered in the "indicate your MCO plan payment reduction amount, per member" field by 80 percent. The resulting number is the Part B premium reduction amount for each member in that particular plan (rounded to the nearest multiple of 10 cents). This rounded number will then be used to populate the corresponding SB sentence describing the Part B premium reduction benefit.

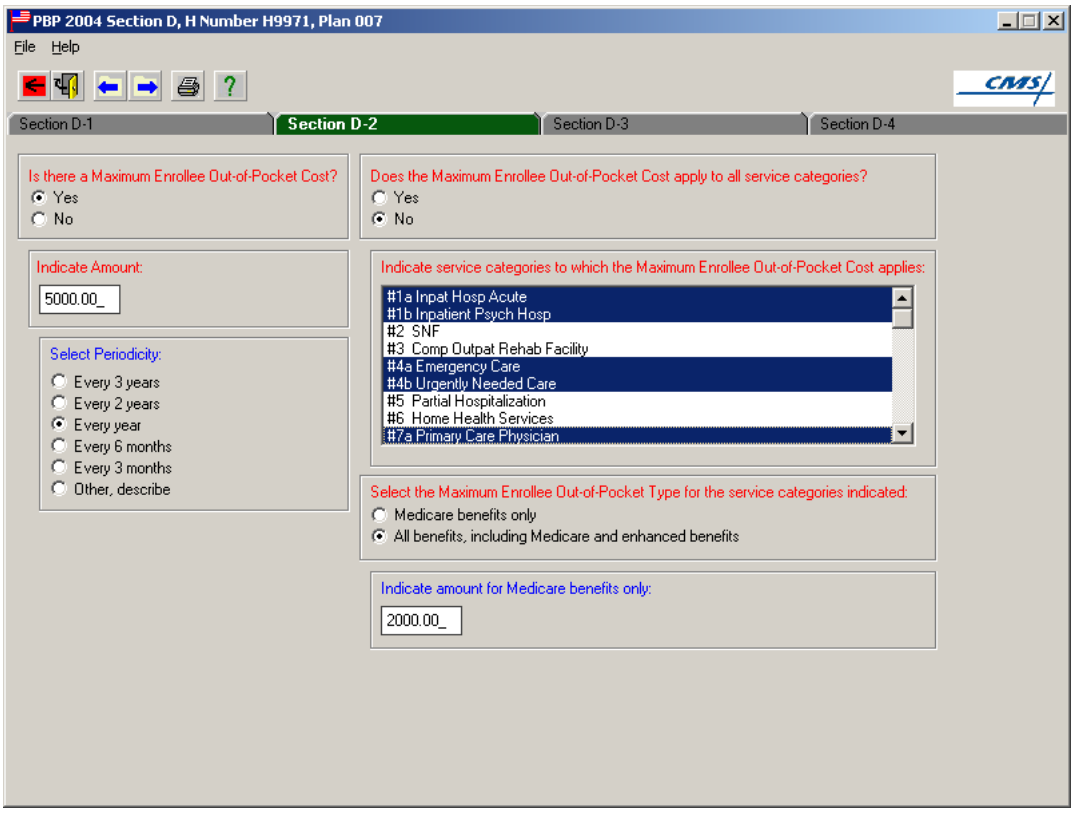


NEW FOR 2004:

Plan-level cost shares and coverage limits can now be specified for all benefits, Medicare only benefits, and for a subset of benefits offered by the plan. For the deductible and maximum enrollee out-of-pocket cost, the MCO can select the benefits included in that plan-level cost from a picklist of all benefits categories. For the maximum plan benefits coverage limit, the MCO can also select the benefits covered under that plan from the picklist.

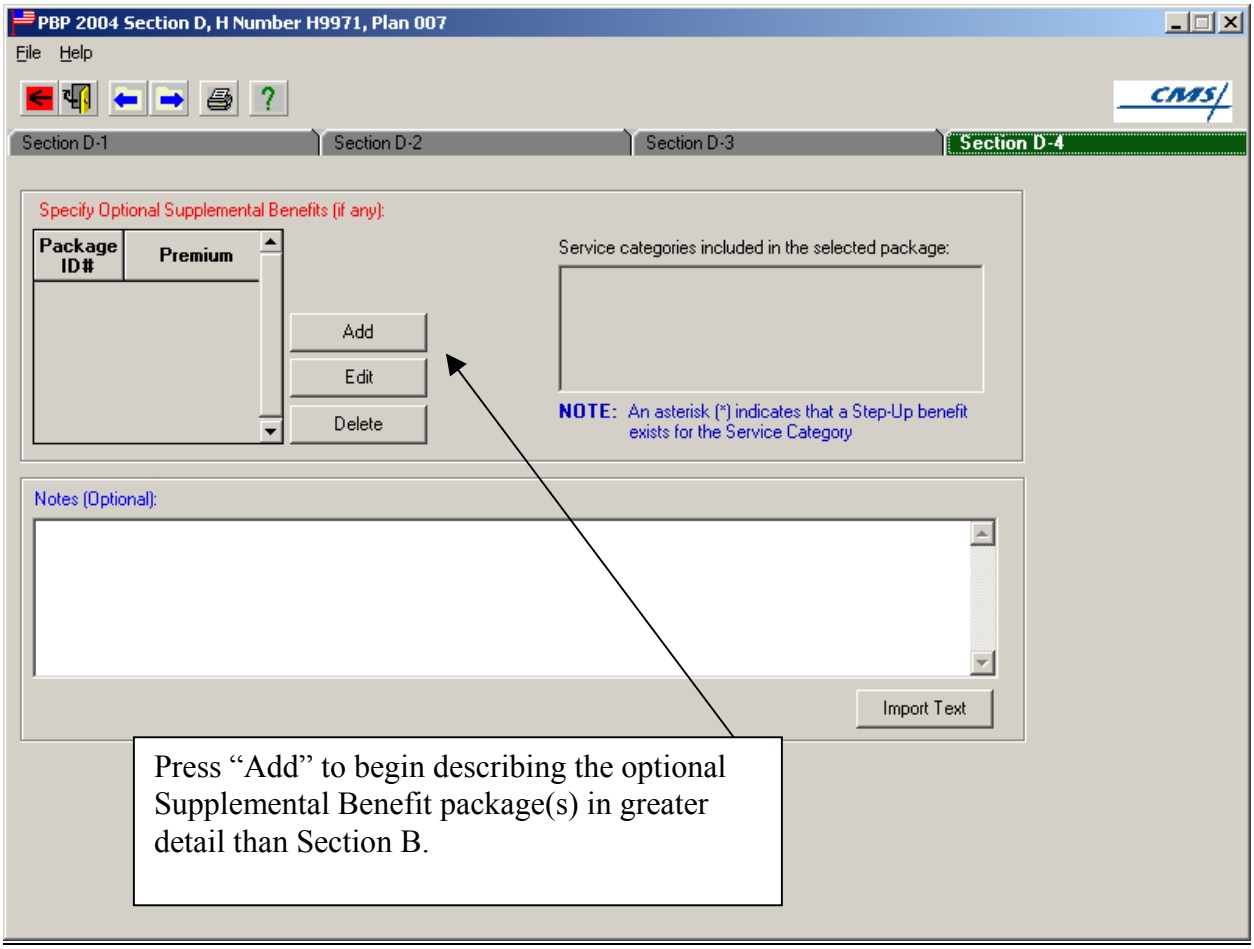
In Section D-2 (pictured below), the user has selected to offer a $5,000 annual Maximum Enrollee Out of Pocket cost for all benefits. This maximum only applies to certain categories, so the user has highlighted those that apply. Since this max applies to all benefits, including Medicare and enhanced benefits, the user must specify what portion of the $5,000 max indicated earlier applies to Medicare benefits only. In this example, a $2,000 annual max applies to the Medicare benefits only and $3,000 applies to the enhanced benefits.

If the user had selected the maximum applied to "Medicare benefits only", then the $5,000 annual max would apply and the "Indicate amount for Medicare benefits only" would remain disabled.



Designation of Optional Supplemental Benefits Package

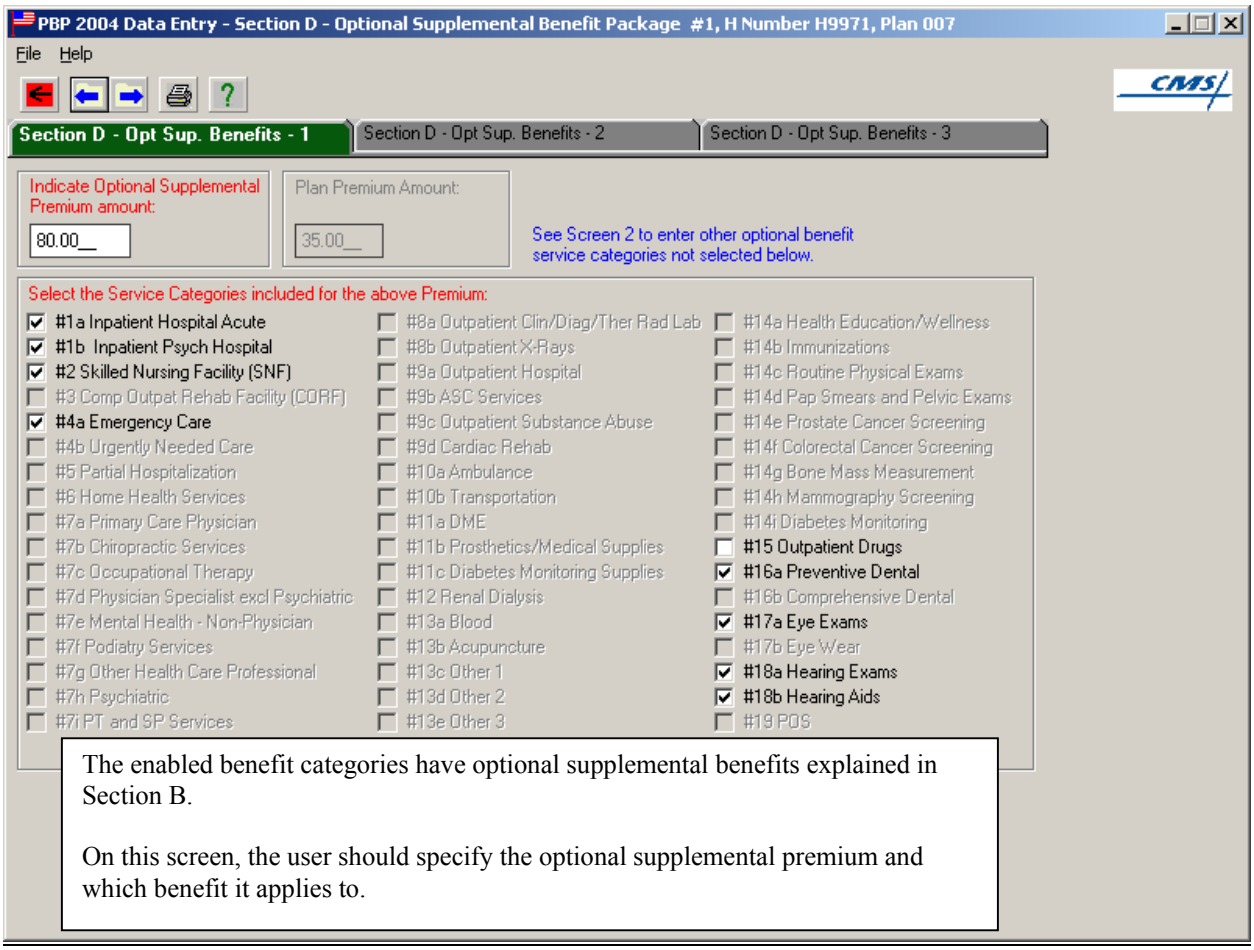
Section D is also used to describe Optional Supplemental Benefits packages offered by the plan. Section D enables the user to create one or more Optional Supplemental Benefit packages with an associated premium.



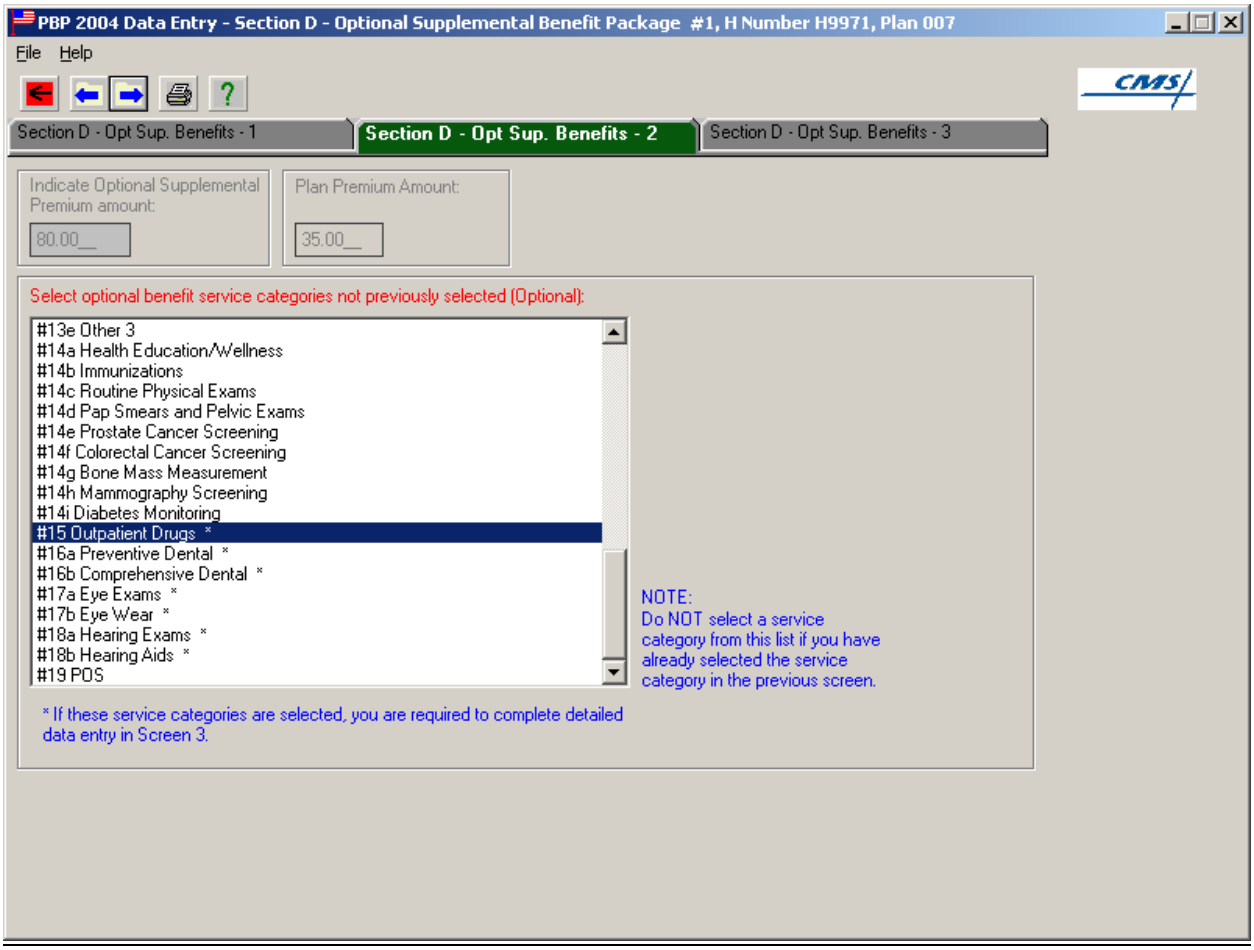
The user must enter the Premium amount for the Optional Supplemental Benefits package and select from the pick lists on screens 1 and 2 the set of service categories that describe the optional supplemental benefits included in that package.

On the first screen (below), the plan selects one or more benefit subcategories enabled based on benefits designated as Optional in Section B.

NOTE: Each enabled subcategory must be included in at least one Optional Supplemental Benefit package.



In addition, the MCO may also select, on the second screen (below), other service categories containing optional supplemental benefits within a designated package.



NOTE: A service category should only be selected once between the two screens, so it is not repeated in the list of service categories included in the package.

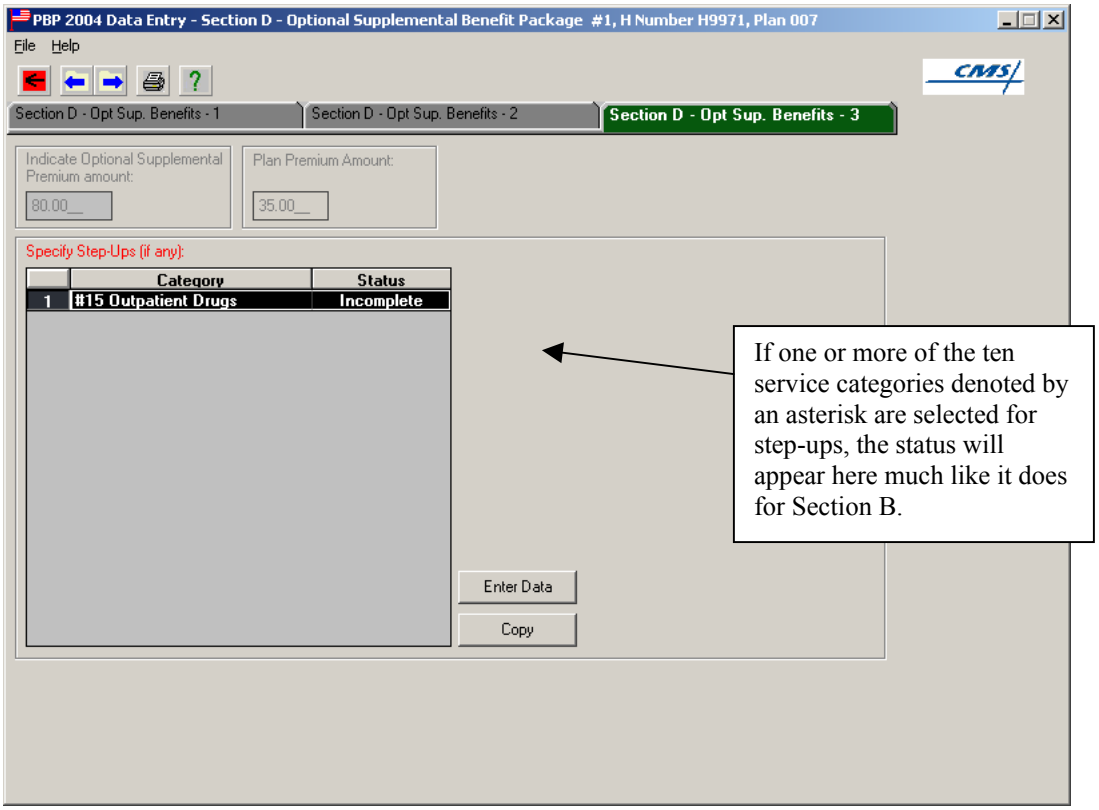
If one or more of the Optional supplemental benefit(s) denoted with an asterisk (*) are selected, the user must then describe these benefit on the third screen. The data entry screens for these ten step-up benefits are similar to the screens in Section B. **If the package includes a step-up benefit that is not one of these ten, then the plan must describe the step-up benefit in the category Notes in Section B.**

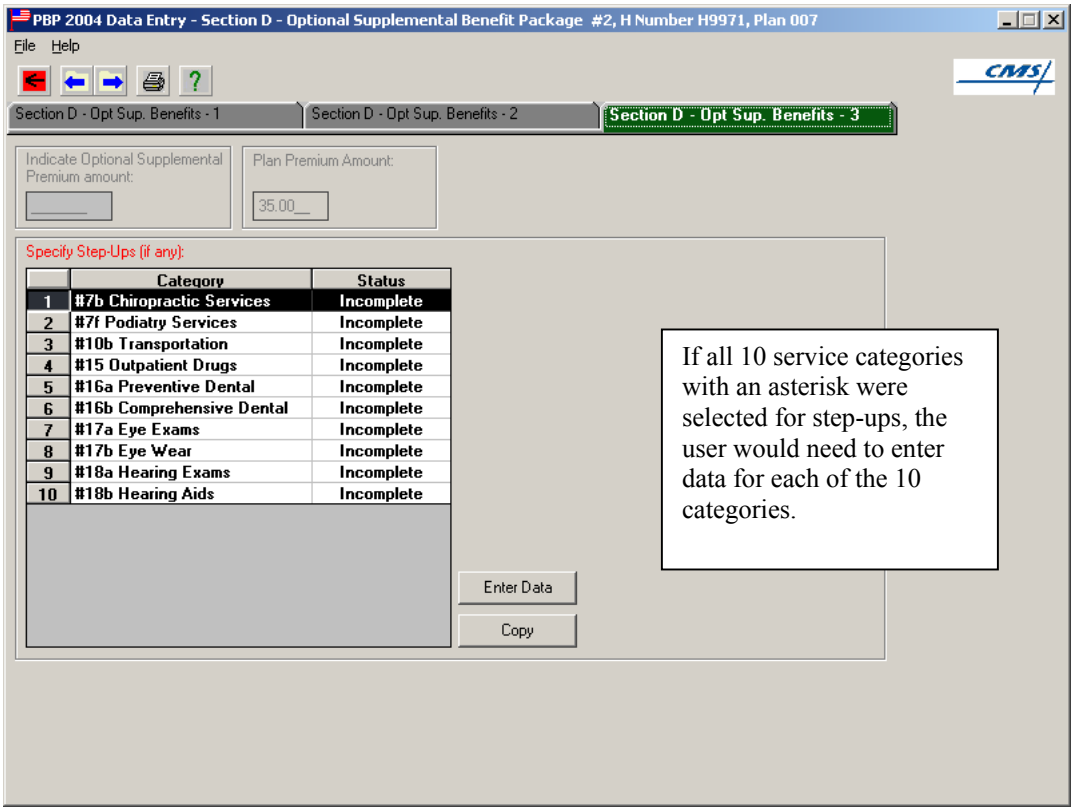
The ten Optional step-up benefit categories are:

- Chiropractic Services (7b)
- Podiatrist Services (7f)
- Transportation Services (10b)
- Outpatient Drugs (15)
- Dental - Preventive Services (16a)
- Dental - Comprehensive Services (16b)
- Vision - Eye Exams (17a)
- Vision - Eye Wear (17b)
- Hearing - Hearing Exams (18a)
- Hearing - Hearing Aids (18b)

Specify the step-up benefit by highlighting one subcategory at a time from the Category column and then select either the <Enter Data> or <Copy> buttons. If the <Enter Data> button is selected, the appropriate subcategory's screens will automatically appear for data entry. The step-up data entry screens are similar to and should be completed in the same manner as the Section B screens.

As an alternative, if the <Copy> button is selected, data previously entered in Section B for the subcategory will be copied to the step-up benefit subcategory screens. However, the step-up data entry will have an "Incomplete" status until the step-up modifications are entered in the step-up benefit subcategory screens.




PBP 2004 Data Entry - Section D - Optional Supplemental Benefit Package #2, H Number H9971, Plan 007
File Help
Section D - Opt Sup. Benefits - 1
Section D - Opt Sup. Benefits - 2
Section D - Opt Sup. Benefits - 3
Indicate Optional Supplemental Premium amount:
Plan Premium Amount:
35.00
Specify Step-Ups (if any):
Category
Status
1 #7b Chiropractic Services Incomplete
2 #7f Podiatry Services Incomplete
3 #10b Transportation Incomplete
4 #15 Outpatient Drugs Incomplete
5 #16a Preventive Dental Incomplete
6 #16b Comprehensive Dental Incomplete
7 #17a Eye Exams Incomplete
8 #17b Eye Wear Incomplete
9 #18a Hearing Exams Incomplete
10 #18b Hearing Aids Incomplete
Enter Data
Copy
If all 10 service categories with an asterisk were selected for step-ups, the user would need to enter data for each of the 10 categories.